IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

UNITED STATES OF AMERICA	)	NO. 4:21-CR-09
	)	
	)	
VS.	)	Houston, Texas
	)	1:08 p.m. to 7:16 p.m.
	)	
ROBERT T. BROCKMAN	)	NOVEMBER 22, 2021

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COMPETENCY HEARING

AFTERNOON SESSION

BEFORE THE HONORABLE GEORGE C. HANKS, JR.

UNITED STATES DISTRICT JUDGE

DAY 6

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APPEARANCES:

FOR THE GOVERNMENT:

Mr. Corey J. Smith
Mr. Lee F. Langston
Mr. Boris Bourget
Mr. Christopher Magnani
U.S. Department of Justice
Tax Division
150 M Street NE
Room 2208
Washington, DC 20002
Tel: 202-514-9623
Email: Corey.smith@usdoj.gov
Lee.f.langston@usdoj.gov
Boris.bourget@usdoj.gov
Christopher.magnani@usdoj.gov

FOR THE DEFENDANT:

Mr. Jason Scott Varnado
Jones Day
717 Texas
Suite 3300
Houston, TX 77002
Tel: 832-239-3694
Email: Jvarnado@jonesday.com

Mr. James P. Loonam
Ms. Kathryn Keneally
Ms. Sarah Efronson
Jones Day
250 Vesey Street
New York, NY 10281
Tel: 212-326-3939
Email: Jloonam@jonesday.com
Kkeneally@jonesday.com

COURT REPORTER:

Ms. Kathleen K. Miller, CSR, RMR, CRR
515 Rusk, Room 8004
Houston, Texas 77002
Tel: 713-250-5087

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NOVEMBER 22, 2021

(1:08 p.m. to 7:16 p.m.)

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12:42:33 THE CASE MANAGER: All rise.

THE COURT: Please be seated, everyone.

Mr. Varnado, you may call your next witness.

MR. VARNADO: Thank you, Your Honor. The

01:08:56 defense calls Frank Gutierrez.

THE COURT: Okay. Mr. Gutierrez, if you can step forward, sir, and be sworn.

(Witness sworn.)

THE WITNESS: Yes, sir, I do.

01:09:10 THE COURT: Please take the stand, sir. You may proceed whenever you're ready.

MR. VARNADO: Thank you, Your Honor.

FRANK GUTIERREZ,

duly sworn, testified as follows:

01:09:23 **DIRECT EXAMINATION**

BY MR. VARNADO:

Q. Could you please state your name and spell your last name for the court reporter.

A. Yes, sir. Frank, last name is Gutierrez,

01:09:32 G-U-T-I-E-R-R-E-Z.

Q. And how old are you, Mr. Gutierrez?
A. 62.
Q. And what city do you currently live in?
A. Houston, Texas.
01:09:38 **Q.** And how long have you lived in Houston?
A. All my life.
Q. And what is your current occupation?
A. Healthcare provider --
Q. Okay.
01:09:47 **A.** -- home care.
Q. And how long have you worked in home healthcare?
A. Around 15 years.
Q. Now, do you have any medical degrees?
A. No, sir.
01:09:56 **Q.** Do you have any professional medical training?
A. No, sir.
Q. Are you a licensed medical professional in any way?
A. No, sir.
Q. Have you done anything on your own to learn about
01:10:09 dealing with patients who have Parkinson's disease?
A. Yes. I have gone to some seminars. I have also gone to HAPS, which is Houston Association for Parkinson's, and they have a lot of people that work -- that have PT, OT, and they have -- provide services for free for people that
01:10:29 have Parkinson's, and that's where I go, and I learn a lot

from them. They teach you and everything.
Q. Okay.
A. Yes.
Q. What about attending doctor visits with patients that
01:10:39 you have taken care of, in addition to Mr. Brockman?
A. Yes. I have learned a lot from Dr. Jankovic. I've worked -- been with him for about six years -- five years. Five years.
Q. Let me pause for just a moment there. Is that in
01:10:52 connection with your care for Mr. Brockman or someone else?
A. Someone -- someone else, yes. And then Dr. Willerson, also, from St. Luke's, cardiologist, which I was with him for about six years, yes.
01:11:06 **Q.** So -- and we will talk about some of the additional people that you have helped in addition to Mr. Brockman --
A. Yes.
Q. -- in just a little bit.
So, in terms of your employment, do you
01:11:14 work for a home healthcare company?
A. Yes, sir.
Q. What's the name of that company?
A. Texans Home Care.
Q. All right. And is that -- who is the patient that
01:11:22 you're currently working with right now?

A. Mr. Robert Brockman.
Q. And how long have you worked with Mr. Brockman?
A. Right now, it's seven months. Seven months.
Q. So when did you start? What's the month?
01:11:36 **A.** April the 15th.
Q. Of this year?
A. Of this year, yes, sir.
Q. And do you know why your services were sought in April of this year with respect to Mr. Brockman?
01:11:47 **A.** I spent a lot of time with the patient. I am usually the one that takes care of him 12 days, 12 hours a day straight, and I get two days off. And, so, it's 12 and two, 12 and two.
Q. Okay. And I want to just ask if you knew -- had
01:12:04 anything happened to Mr. Brockman prior to you being hired to provide personal care for him?
A. Yes. I was told by his wife, Ms. Brockman, when we had the interview to go talk to her about care, that he was -- had been hospitalized in March for an infection,
01:12:27 and he had been very ill and, so, he needed assistance at home. And -- and was asking about me, and we told them I had experience with Parkinson's people, or patients. And, so, yes.
Q. Okay. And we will cover that.
01:12:43 **A.** Yes.

Q. Are you a little bit nervous today?
A. Yeah. I never done this before.
Q. You're doing fine.
A. Okay.
01:12:48 **Q.** So, just take a deep breath.

We will talk about your schedule in more detail, but I think since you mentioned it -- you said it was 12 days, 12 hours a day, and then two days off?
A. Yes.
01:13:01 **Q.** And what time of day are you typically assisting Mr. Brockman?
A. 7:00 in the morning until 7:00 p.m. at night, and maybe sometimes a little longer, depending how long the night caregiver -- because if he has problems or
01:13:14 something, he's running late, I stay there until he gets there.
Q. Okay. And, so, does somebody else provide care in the overnight hours for Mr. Brockman?
A. Yes. Yes.
01:13:22 **Q.** Is that someone else who works with your same company?
A. Yes.
Q. The same company you work for?
A. Right.
01:13:27 **Q.** Okay.

A. Right.

Q. Now -- so, presently, you are taking care of just one person and -- Mr. Brockman?

A. Yes. Yes.

01:13:35 **Q.** And have you done that before, cared for somebody full-time, just one individual?

A. Yes. Yes.

Q. How -- give us an estimate of how many people you have done that for over your 15-year career.

01:13:47 **A.** I had two other -- two other patients, and I had one that I worked full-time, but, also, I had -- the days -- I had a little bit more days off. I'd take care every other weekend on another patient that had Parkinson's.

Q. So that was my next question.

01:14:06 **A.** Yes.

Q. For any of these individuals that you provided care for previously, did any of them have Parkinson's?

A. Yes.

Q. How many?

01:14:14 **A.** Two of them. Two other patients, yes.

Q. And was one of those patients somebody that you cared for over a five-year period?

A. Yes. Yes.

Q. And did that person have dementia as well as Parkinson's?

01:14:25

A. Yes.

Q. Okay. And do you -- when you provide care in this manner, on an individualized basis, do you typically stay and assist that person until they pass away?

01:14:39 **A.** I do.

Q. Do you go directly from one patient to the next or do you take some time off?

A. No. I -- I usually take about a month off.

Q. And why is that?

01:14:49 **A.** You spend so much time with them and you become part of their family, and they really need your help, and they depend on you every day. Their day doesn't start until I get there and get them out of bed. So, yeah, it takes something out of me, and I can't really help another

01:15:15 patient until at least I get ahold of myself. So, I take about a month before I get another patient.

Q. Okay. All right. I'm sorry, Mr. Gutierrez.

MR. VARNADO: If I can approach, briefly, Your Honor.

01:15:26 THE COURT: Yes.

THE WITNESS: Oh. Thank you.

BY MR. VARNADO:

Q. So, as you have been engaged in this work, have you had any difficulty finding another job, you know, if one

01:15:43 of your patients passes away?

A. No, sir. Not at all.

Q. Is it fair to say that here in Houston your services are in high demand?

A. Yes.

01:15:51 **Q.** Have you actually turned people down who have tried to hire you in the past?

A. Yes, I have.

Q. And what would be the reason for that?

A. Because I don't have enough time to be able to take

01:16:04 care of them, you know, certain -- Like one patient I had before, I was able -- I had a little time. So, that's why I had a part-time one and the other one. This was two a week -- Every other weekend, that one, I had a little bit of time for him. But, with the other ones, I really

01:16:19 didn't have any more time. Even with Mr. Brockman, I just don't have time.

Q. Now, are you paid a monthly salary or an hourly salary?

A. Hour salary.

01:16:26 **Q.** And what is the hourly rate that you are paid?

A. $17 an hour.

Q. Okay. Now, do you have any sort of side agreement with the Brockmans where you get paid additional money beyond what we just talked about?

01:16:36 **A.** No, sir.

Q. Okay. I would like to see if you can recall the first time that you met Mr. Brockman. Do you recall approximately around, you know, what month and year that was?

01:16:46 **A.** It was April the 14 -- I believe April 14th of this month -- of this year, I mean. And I had an interview with his wife first, me and my supervisor from the company. And we were talking. And then as I was talking, I noticed Mr. Brockman coming in, because he heard us 01:17:05 talking and he walked in. And, so, I usually try not to really focus on them. I kind of look on the side because I want to catch them to see what -- how they are in their state, you know, and see how bad -- how serious their Parkinson's are. And I could see that his walking and his 01:17:20 balance wasn't that good, and he was kind of hunched over and stuff. That kind of seems the similarities that I have seen in Parkinson's. So, yeah.

Q. And was your prior experience with another person who had Parkinson's one of the reasons your supervisor thought 01:17:34 you would be appropriate for this assignment?

A. Yes. Yes.

Q. And during that first meeting were you able to observe Mr. Brockman?

A. Yes. I was able to look at him and -- and I could 01:17:48 tell, too, in his talking a little bit, from his -- you

know, when he was trying to talk, that it wasn't really quite -- I couldn't make out really what he was saying, and his voice was somewhat low, like usually what happens with Parkinson's.

01:18:01 **Q.** So, I want to ask you some questions about a typical day for you in caring for Mr. Brockman, and let me start by first: Do you, as part of your work for the home healthcare company, prepare a daily log of some sort recording, at least, some of your activities during the

01:18:17 day?

A. Yes. We have a sheet there that -- you know, just something that I normally even do -- I do, is I fill it out and just put whatever I can, when I can, because I am usually a lot with the patient, so --

01:18:30 **Q.** Is that log intended to cover all of your observations throughout the day?

A. No. No.

Q. What is the primary purpose of the logs, from your perspective?

01:18:41 **A.** Just a little bit idea to make sure that it shows that we gave him his meds, and that he -- how much he has been eating, because eating is very important with Parkinson's patients because they tend to lose a lot of weight. And, so, if we start seeing some of that, that

01:18:56 could kind of indicate we need to keep an eye, you know.

Q. And if we were to look at some of those reports, from time to time are there references to Mr. Brockman's --

A. Uh-huh.

Q. -- "confusion" in those reports?

01:19:06 **A.** Yes. Yes.

Q. That word?

A. Yes.

Q. Now, if we were to look at a report and it doesn't have the word "confusion" in it, does that mean that

01:19:13 Mr. Brockman didn't show any confusion that day or --

A. No. No.

Q. So, it's not meant to record everything that happens --

A. Right.

01:19:20 **Q.** -- in a single day?

A. Right.

Q. So, again, turning to a typical day in your care for Mr. Brockman, let's just start with the first thing in the morning. What's the first thing that happens when you

01:19:30 arrive at Mr. Brockman's house at 7:00?

A. When I come in, I usually talk to the night caregiver, kind of report a little bit, see what -- how was his night. You know, did he sleep good? Did he have problems with anything?

01:19:43 And then, after that, I walk into their

bedroom and I will say good morning to them. And then I'll ask Mr. Brockman, "How you doing?" You know, "How are you feeling today?" and "Did you sleep good?"

And then I'll determine where to start from there. The reason I say that is because it could be like he says, "Well, I had" -- "my back has been bothering me right now." And, so, if his back is bothering him, I want to put him some lotion, cream, that's for -- and I have a little massager in my bag that I'll massage him to kind of help him a little bit.

And then I'll go to do stretching his legs. I usually want to stretch them out a little bit, their legs and arms, so, that way, they could be a little bit looser to start the day when they get up.

Q. Okay.

A. And then I'll get them up in the bed, but I usually wait a little bit. I don't rush them up, because if you rush them too quick they have a tendency -- they could fall. So, you've got to give them a little time to sit there on the edge, and then I'll tell him, "Are you ready, Mr. Brockman?" Then he'll get up. "Do you want to go to the bathroom?"

Q. So, can Mr. Brockman get out of bed on his own or does he require your assistance?

A. He requires my assistance.

Q. Then, after you're up and out of bed and going to the bathroom, does Mr. Brockman require your assistance in that regard also?

A. Yes. Most of the time -- a lot of times we will go straight to the bathroom and I'll help him sit there. And then after he's done, I help him to get up, or whatever, because I need to -- I need to take -- clean him and that.

Then we start to put his robe on, and then we will go out to the kitchen to have his breakfast.

Q. And where Mr. Brockman lives now, is he -- is his bedroom on the same floor as the kitchen?

A. Yes. Yes. We try to keep everything simple, so yes.

Q. And, so, are you -- is your help needed to get him from the bathroom into the kitchen?

A. Yes. Yes. We have a -- sometimes his -- I look at -- what I do is I look at his walking, and if his feet, steppings, are not proper, or is crisscrossing, or kind of weak or bent over, I want to get him the walker and we will use the walker and I walk that way. If he walks pretty good some days, then I will just walk alongside him and hold his arm.

Q. Okay. And then when you get to the kitchen what happens next?

A. We start -- we sit him down, and then we have a newspaper there so he can kind of just keep up with that

while we make his breakfast, which is a normal breakfast, toast and coffee.

And then I start getting his morning meds together and a MiraLAX and stuff that we mixed up so he can drink with the meds. And I now stand there and watch him take the medicine because I want to make sure he takes them all, he doesn't drop any or loose some.

Q. Is Mr. Brockman -- so, I take it somebody else prepares his breakfast?

A. Yes. We have a cleaning lady there. She's very sweet. When she can -- the majority of the time she can, she'll make his breakfast. If not, if she's like caught somewhere else, I'll run over there and I will just make it for him.

Q. Is Mr. Brockman capable of making his own breakfast --

A. No.

Q. -- in the morning?

A. No.

Q. And then, in terms of his medication, who is in charge of ensuring that proper doses are administered in the morning time and then throughout the day?

A. I make sure that he takes it.

Q. Could Mr. Brockman administer his own medications?

A. No.

Q. So, after breakfast, can you give us a little feel for what happens next in a typical day with Mr. Brockman?

A. After breakfast, if his wife comes out, he will sit there a little bit and wants to talk to his wife. But, if not, then we start the process of walking back and getting ready for his shower.

01:22:54

Q. Okay.

A. And, so, we will walk back to the shower room, and there I'll start to remove all his clothes. I have him holding on to the sink and stuff, and I remove his clothes. And then I walk him into the shower. And then we had -- I had them install some bars in there so he would be able to hold on, some really nice bars, so he can stay in that area. And then he starts showering, and I get all his clothes together, and then the towels to dry him off, and other medicines that I have to give him also and then -- when he comes out.

01:23:05

01:23:21

Q. Is Mr. Brockman capable of removing his clothes to get ready for the shower on his own?

A. No. No.

01:23:32

Q. Okay. So, after Mr. Brockman is taking his shower, do you help him get dressed?

A. Yes, I do. I'll open the door and I'll grab a hold of him so he can get in -- back into the restroom and walk him over to the sink, hold on there, and I'll start drying

01:23:45

him all off, from top to bottom, real good.

And then I put a patch, a patch that he has to have and --

Q. That's a medication patch?

01:23:57 **A.** Medication patch. Yes, he's got to have a patch.

And then I'll start putting -- I scratch his back because he has a lot of itching in his back, because some of the meds cause that. And, so, I got a little brush that I'll brush him for a little while just

01:24:11 to help him, make him feel good.

Then I put this tube of Testim -- so, two tubes of that. It's a testosterone tube lotion. I rub it real good into his skin because it's got to absorb into the skin. You can't just put it on. You got to work it

01:24:24 into the skin. Then I'll put some lotion. The dermatologist wants me to do that because there is certain -- those spots that she's kind of worried about, all over certain-- body and face and head. So, I do all that.

01:24:35 Then it put some Arthro gel, which is a cream for his back, lower back, and his hips. So, that gives me a good head start for the day. It helps him out.

Q. Okay.

A. Yeah. Yeah.

01:24:45 **Q.** And then do you help assist Mr. Brockman in actually

getting dressed for the day?

A. Yes. Yes. And that -- I have to coach him to step back. There is a seat behind us, a couple or maybe three steps. But I hold him and he casually -- kind of cautiously steps back, and I go, "Okay. Keep going for one more step." Then I will sit him down.

And then I'll -- what I'll do is I'll start combing his hair. And if he needs to shave, I'll shave him and I give him a good shave, real good shave. I used to let him -- when I first started, he did his own shaving, but it was all -- he didn't do it right. It was everywhere -- patches everywhere. So, I took charge of doing that also.

Q. Okay. So, at this point in time, Mr. Brockman is not capable of shaving --

A. No.

Q. -- himself?

A. No.

Q. Okay.

A. No.

Q. And then you also -- he's not capable of combing his hair --

A. No.

Q. -- and his personal grooming --

A. No.

Q. -- aspects?

Okay. After Mr. Brockman is dressed for the day, what sort of happens next?

A. Oh. In the bathroom, also, like I said, I pick his clothes every day. Every day. Since I came in I usually do that. I kind of find out what they like to dress, what their wardrobe was. So, I will get all his clothes and I'll dress him. And he has been very happy with that, the way I dress him and then -- shoes, everything.

So, then we do the -- brush teeth, and pretty much --

Q. You help him brush his teeth?

A. Yeah, I help him brush his teeth and everything. And I got a special brush also, because, before, we can't get a lot of strokes out of him on a manual one. So, I got a battery-operated where it vibrates.

So, there are certain things that I added more to -- for them to help the patient. I talked to the wife.

Q. Okay.

A. Yeah.

Q. And then -- so, after, you know, sort of getting all prepared for the day, is there typically any exercise? What happens next?

A. Yes. A lot of times we will take a walk outside in

the neighborhood. We'll maybe go several blocks down and then take little breaks. We take little breaks down there because he can't walk too much. He has to take a break. So, we'll find a little brick wall or something where he
01:26:33 could sit down and then break a little bit for a while. We'll talk, and then get up, and then we will go again, finish off, and then brought ourselves back home.

Q. Okay.

A. Then I have a lot of times where I do therapy in the
01:26:46 kitchen with a table, for his legs, you know, balance and all that. So, I do some of that. And then I alternate. In other days, I'll sit him on a chair and I'll do it for his legs to try to strengthen his legs so he can have some movements. So, yeah.

01:27:00 **Q.** Okay. And then what about lunch? Do y'all go out for lunch or stay in?

A. No, we don't -- she don't really allows us to go anywhere out. And I take it because -- I think that, you know, because of his dementia and all that, she is afraid
01:27:12 that something -- he might get lost. So, we pretty much stay home. We don't go out. I'm okay. So, we eat lunch at home.

Q. Okay. And when you say "she," are you referring to Mrs. Brockman --

01:27:20 **A.** Mrs. Brockman, yes.

Q. -- would prefer you to stay home with --

A. Right. Right. Right.

Q. -- Mr. Brockman?

And, again, the same questions about food at lunch. Does Mr. Brockman prepare his own lunch?

A. No. No.

Q. Is he capable of preparing his own lunch?

A. No. No.

Q. So, somebody else does that, maybe the --

A. Yes, a lady that's there and she makes the meals. And then she fixes a lot of them, too, that she will freeze them in the freezer for us. So, then his wife will take some out for lunch, let them thaw out, and then we either cook it on the stove or heat it in the microwave.

Q. Okay. Anything else typically happen during the day before dinner or is it just kind of being at the Brockman -- Mr. Brockman's home?

A. It's just being at home. But, you know, I just try to keep up with him, try to stay with him, watch him, keep an eye, because, you know, he just a lot of times gets up and just starts going different directions and I don't know what he is doing. So -- and a lot of times he won't answer you, so I just kind of follow him and just see what he wants to do. But I try to stay as close as I can with him.

Q. Okay. We're going to talk about some specific examples you might want to share. But just to complete the day, is it then, you know, dinnertime and kind of the same routine as we have talked about with breakfast and
01:28:36 lunch?

A. Yes. Yes. She will have something prepared, already heated up for him.

Q. Okay.

A. Yeah.

01:28:40 **Q.** And, again, he's not preparing his own meals?

A. No.

Q. Or dinner?

A. No. No.

Q. And is he able to -- is he able to feed himself and
01:28:49 actually eat on his own?

A. Well, certain things. Say like a piece of chicken breast or something like that, we have to cut it up for him in bite sizes, you know.

Q. Okay.

01:28:59 **A.** And -- and I really don't -- I had talked to the wife before. I really don't want him having any kind of knives or stuff like that because I don't want him to hurt himself.

So I told her just butter knifes is all I
01:29:10 would like for him to have and then if he needs cutting,

I'll assist it. I'll cut everything up. Certain things, some burritos, some kind of tacos, and so I'll try to cut in pieces for him, so, yeah.

Q. Okay. And so after dinner, around what time does Mr. Brockman typically go to bed?

01:29:24

A. It could be anywhere from like 6:00, 6:30, maybe, you know, even close to 7:00. And so we start that process, you know, everybody is ready to go to bed. She is ready to go to bed. And so we will get up and we will go all the way back to the bedroom.

01:29:41

And when we get to the bathroom, I'll go ahead and right away give him his nighttime meds so he can take it with water there while he is standing there.

And then I'll ask him, I'll remove some of his clothes, but I ask him if he wants me to help him put some pajamas on. Sometimes he says, yeah. So I pick up some pajamas and put them on. And I have these special socks that I had ordered for him that have rubber on the bottom so he won't slip when he walks because, you know, a lot of times he tries to get up when you're not looking and so those socks are really very handy for him to have.

01:29:52

01:30:06

Q. Then do you assist Mr. Brockman in getting in -- into the bed?

A. I do, yes.

Q. Can he get into the bed by himself?

01:30:14

A. No. No. No. I have a procedure that I do. I get him all the way close to the bed where the pillow is at, and then I have him kind of get there and then I kind of help him sit down. Then I have him cross his legs, and
01:30:30 I'll hold his shoulder and his leg, and I'll lift the legs, and I turn his shoulder this way so he can fall straight over his pillow.

Q. And he couldn't do that without you?

A. No. No. No.

01:30:39 **Q.** Okay. And so during the last seven months that you have been working with Mr. Brockman, have you observed a change in his physical health from the time that you began to today?

A. Yes.

01:30:51 **Q.** And is it better or is it worse?

A. It's worse.

Q. Okay. And the same question with his mental health, is that improved or -- or gone down?

A. It's gone down.

01:31:03 **Q.** Okay. We will talk about each of those, but in terms of his physical condition, what are some of the things you have noticed that are changes in Mr. Brockman over those seven months that you have worked with him, whether it's his weight or his ability to walk, whatever you have
01:31:17 observed?

A. Well, that is one thing we noticed, is that he lost -- he lost weight. He used to weigh like 190, and then he has gone down to like 172, and so I brought that attention to his wife because Parkinson's patients do lose
01:31:31 weight. And then when they lose weight, I found out that it's very difficult to gain that weight back on him.

And so I let her know, I said, I think we need to look into what he is eating. He is not eating as much as before, like he was before. And also the food
01:31:44 that he is eating is not going to help him gain any weight.

Q. What do you mean by that?

A. Well, he is eating like -- they make like salad or a little soup, stuff like that, fruits. And so with that it
01:31:55 is going to be -- it is healthy but is it not going to help him gain weight, and so we are going to lose more and more. And, like I say, it is very difficult to do that, very difficult.

And so she is kind of listening and she
01:32:06 tried to change some things, you know, but I feel like not enough, but that -- yeah, that is what we do.

Q. How about his ability to walk? How is that compared to when you first started?

A. His walk is different. There is times that you have
01:32:17 to -- like I said, you have to look at him and his steps

that are okay. Okay. So I can walk with him. And then there are times when he is stomping a little bit. He is not really walking. It's more of a caution walk and stuff, slide. So I had to keep an eye on that and, like I
01:32:30 said, we use the walker for that, so I make sure that he doesn't fall down. Yeah.

Q. So he uses a walker at home from time to time?

A. Uh-huh. Yes.

Q. Okay. What about just his strength, whether -- in
01:32:40 his arms and his ability to hold things, have you noticed any change there?

A. Yes. We -- one of the exercises I do in the patio because I like to get him out a little bit on his patio there is do some exercises there and we have some weights
01:32:51 and stuff.

And when I first started it was like five pound weights he was able to lift and stuff. Now, since he came back from the hospital and all that, it is not -- we have to decrease on the weights. We were down to two
01:33:02 pounds and he couldn't really do it. It was too much. He didn't want to do it.

So I said okay, so I gave him one pound in each hand. I said, We will just do one and then we will work our way back up to that, so that's normally what
01:33:12 we're at, is at the one pound weights on there.

Q. Do you try to encourage Mr. Brockman to exercise?

A. I do. I tell him, I said, Mr. Brockman from my experience working with Parkinson's, you have to exercise. You have to at least do twice a day, and then do normal stuff, move around.

01:33:25

You got to move because if not it is going to decrease, and it is going to be backwards we are going to go, and so we are going to be more dependent of the walker, or more of the -- later on that you are going to have to use a wheelchair. And those are going to be very difficult.

01:33:37

My job is to try to not -- to help you so you don't depend much on these things, and if you listen to me, I can help you, you know.

Q. And so how has that over time been in terms of Mr. Brockman listening to you, and being, you know, receptive to what it is you are trying to get him to do physically?

01:33:47

A. It's been very difficult. You know, I try to work out, that I tell him, said we need to do exercises. And he just looks at me. He goes, I got stuff to do. I have to get my paperwork. I have to get my suit case.

01:34:01

And I say, Well, you know, we need to do this, you know. I will do it later on. So he has been very difficult to coach him into doing a lot of -- like he

01:34:16

did before in the beginning, yeah.

Q. I want to talk about some of those sort of confusion episodes in a minute. But let's talk about just, we covered the physical aspects with Mr. Brockman. You said you had also noticed a decrease in Mr. Brockman's mental capabilities --

A. Yes.

Q. -- as well?

A. Yes.

Q. And you were already working for the Brockmans, I take it, when -- when Bob was hospitalized in late May and early June?

A. Yes.

Q. Okay.

A. Yes.

Q. And let's talk about that. Were you with Mr. Brockman that day when he was taken to the hospital?

A. Yes.

Q. Tell us what happened -- what you observed that day that led to Bob being hospitalized.

A. Are you talking about the one in May?

Q. Yes.

A. May. Okay. Yes. That particular day I came in, and my night caregiver didn't say anything, just normal. I said, Okay. So I did my normal stuff with him and stuff

like that, stretch him and everything, got him dressed. Went to the breakfast table, had breakfast. And then he kind of looked different there, but he ate his breakfast, but he was kind of different and then he got up. And
01:35:20 normally, like I said, he either talks to his wife or he goes to shower. Well, the wife wasn't there.

He went to the long sofa, sat there, and I said, What are you doing, Mr. Brockman? He said, I'm just going to rest here for a little bit. I said, Okay.
01:35:32 Because I thought he was tired. I said, Okay, rest there a little bit. He didn't sleep good.

But he was -- started like falling asleep in a deep sleep and everything. And he didn't -- I said -- later on he didn't even want to take the shower. I
01:35:43 said, okay, just let him rest. Maybe he's exhausted.

So lunchtime came. He never got out of the sofa, but lunchtime came. She fixed something, and then we went and walked over there to the table. I helped him sit there. And normally, like I said, he eats really
01:35:57 good his meals and so this time he just took like a spoonful like this and then he set -- then all of a sudden he just stayed there like that, had a glazed look, just like he wasn't even there.

I said to myself, something is up here.
01:36:08 He's got something going on. So I started doing his

vitals and everything. The vitals were okay, except for the temperature was a little bit up. And so I couldn't figure it. I said there is something going on. I said, but we need to take him -- I am going to take him to a doctor.

01:36:21

So this is -- she is brand new, Ms. Brockman is brand-new to me, so she don't know if she would -- I don't know if she would understand or would trust me in saying what I want to do.

01:36:29

So, I called my supervisor. I said, Look, he doesn't look right. He's got a glazed look. He's like -- he is out of it and something is wrong with him. I want to take him to urgent care which I love to go, part of Methodist. I said, I want to take him there and check him out, and if there is anything wrong, they will find it; if not, we come home with a good bill of health.

01:36:42

So I said, but I need you to explain to the wife because she might -- because you're the company owner and everything that -- so he did. He talked to her, and he told her that my guy Frank feels that Mr. Brockman is not well, that he needs -- he wants to take him to the clinic right now so they can at least check him, let's go ahead and do that. So I did, I take him there.

01:36:53

Q. And you said urgent care, was this an urgent care associated with Houston Methodist?

01:37:07

A. Yes.

Q. And then ultimately was Mr. Brockman admitted to the hospital at Houston Methodist after that?

A. Yes. Yes. As a matter of fact, they said -- they started right away when I took him to Methodist, taking -- finding out, they put some I.V. in him and they took some urine sample. They took blood out of him because they wanted to see what was going on.

And then later on they determined that he had some type of infection, but that we need to take him to Methodist, and I am going to have an ambulance come here and take him. And so I said, Great, I told them I agree with that. Let's do that, you know.

Q. So Mr. Brockman was transported to the hospital?

A. Yes. Yes.

Q. And how long was he in the hospital?

A. You know, he was there for a long, long time. Normally, some of the UTIs I had before, you know, three days, maybe five days, but he was in there, I think, around 10, 12 days.

And I even was talking to his doctors like five days before, four days before, I said I would like to make sure that he is -- because he is not well. He is still not well, you know. I know y'all are working on this infection and you're giving him the antibiotics, but

I can tell by looking he is very confused.

He doesn't know what is going on and it is going to be very difficult for us to bring him home like that. I said, because, when I leave, the guys at night
01:38:22 don't know how to handle this, and she is only there and she cannot take care of him. If he falls down or starts to, there is nothing she could do.

So I need more time if you allow it, and he did, the doctor did, said, Okay, we will extend it.
01:38:34 That's why we got it to 12 days.

Q. So, ultimately, he was in the hospital for about two weeks --

A. Yes.

Q. -- to get to a place --

01:38:39 **A.** Yes.

Q. -- where he could come home?

A. Yes.

Q. And did you -- you know, after that hospitalization, have you observed changes in Mr. Brockman in terms of his
01:38:48 mental capabilities, any -- any differences that you noticed, any, you know, experiences that you have had with how Mr. Brockman has behaved?

A. Yes. I noticed that when we came back, there was a lot of -- he was very confused. He didn't know what was
01:39:04 going on. He didn't know where we were at. His walking

was not proper. It was very weak. He was leaning so much forward, he was walking real -- kind of like -- so I took away the exercises that we did outside because I didn't feel like it would be safe for him or us to take him out there.

01:39:22

So I said if we are going to do anything, we will try to keep it a minimum in here. But he was -- a lot of stuff going on with him now. You could tell his mind-wise -- he started talking about things that didn't make no sense.

01:39:32

Q. Well, let me ask you some examples of some of that. Did you notice anything about Mr. Brockman, you know, packing up a briefcase or anything like that, and tell the Court what you observed?

A. Yes. He has been standing up and all of a sudden looking around, and I would ask him Mr. Brockman, What are you doing? He said, I need to get my briefcases together and some of my paperwork. I said, What for, sir? He said, Well, I am going to the office. I said, Okay.

01:39:42

01:39:57

I said, Sir, we're at home. He said, I know, but I'm going to leave here. I have to leave here. And then he had this look, when he came from the hospital, he has like he is really mad or something. You can tell in the expression.

01:40:09

And so I said, Okay. I'm just going to

follow with him and let him do what he needs to do because I don't want him to really get upset. So he will walk around and he is opening doors. He doesn't like -- know where he is going, you know, with his briefcase.

01:40:20 Finally we go to the office and he is just standing there, and then he finds some cases under the desk, pulls them out, looks at them. He opens them up, and then he's not putting anything in there. I just watch him, you know, he will grab like a pen or a paper, and

01:40:34 then he lifts them up and he puts them right in front of the entrance to the door of the office right there. And so he got two suitcases and he opens a big suitcase, you know the key for this? I said, No, sir, Mr. Brockman, I don't know where the key is for that.

01:40:46 But he has it open, so I don't know anything. So he is looking. So he has got -- this has to go with me. And so then he grabs it, so he has his suitcase. Then he has a white container under his desk that has paper stuff in it. He is trying get it out.

01:41:01 What are you doing, Mr. Brockman? Says, This has to go. I said, Okay. So I leave it there. And then I let him -- after a while then he just kind of sits there and then glazed thinking and stuff. Okay.

Q. Is that -- so how have you dealt with that,

01:41:15 Mr. Gutierrez? I mean, do you just sort of let Mr.

Brockman pack up his bags, and then --

A. Yes.

Q. -- hope he forgets, or what happens?

A. Yes. Well, after that, I try to say something to him, so I am going to wait for a time that maybe he rests or do something else. And we can kind of, 'Want to go to the front room, your wife is there?' And he goes, 'Yes.' I say, 'Okay.'

So I will sit him there, and she is talking to him. That is when I go back there and I'll grab the suitcase, and instead of putting them in the same place, I hide them because I don't want him to see it because if he's sees it, it just restarts what we have been doing -- what he been doing.

So I put all those things and I hide them in different places, and I let the wife know sometimes, 'Hey, look, I hid his stuff because, if not, he is going to go back again.'

And I'm afraid he might even go to the point that he wants to start walking outside and we are going to have a problem.

Q. Have you had any situation where Mr. Brockman, you know, during a meal, believed he was somewhere other than his own home?

A. Oh, yes. We had quite a bit where he's -- he thinks

he's at a restaurant. He will say, 'This food is really good here at this restaurant.' And I say, you know, 'Oh, okay.' Then he says, 'Who is going to pick us up?' I said, What?' He says, 'Yeah, who is going to pick us up and take us home?'

01:42:20

And then, like I said, sometimes, I look at him and his face and I see if I can get away with it or something, I will say, 'Well, Mr. Brockman, we are at home. You are at dinner here at home. There is nobody going to pick us up, you know.'

01:42:30

Other times he's -- like if he is really kind of agitated or something, I just leave him alone and say, Okay. I will find out. What I found out, a lot of things when he gets mad about certain things -- he gets mad at me because he thinks I am not well prepared when he's doing things to go to the office.

01:42:43

He will look and me and say, 'What is your role at the office?' Like, what are you supposed to do at a meeting or something, I say, 'Mr. Brockman, I don't work at your office. I work for you. I am here to take care of you.'

01:42:55

Q. So, he is confusing, or I guess, is it your under -- is it impression he was thinking you were working for him at the business --

01:43:06

A. Yes.

Q. -- and not as a caretaker?

A. Yes. And so, yeah, so when he does that I kind of just -- what I used -- what helped me a lot is because he is really good friends with Tommy. He loves him. So I will say 'Look, Tommy is going to come later on this afternoon or tomorrow. We will find out. We can ask him.' And sometimes it's like, 'That's a good idea. Okay.' And --

Q. He will just kind of move off?

A. Move off and then we just hopefully maybe have him concentrate on something else.

Q. Have you ever had any circumstances where Mr. Brockman was confused about where he was in his own home?

A. Yes. A lot of times he thinks that this is a nice hotel. You know, 'When is the airplane going to pick us up?' And, 'Who is going to pilot the plane?' I says, 'I don't know that, sir.'

'Where is my keys to my car?' I said, 'What for sir?' He said, 'I am going to drive us home.' You know, and so, I don't know, so we got trouble here. I don't want him to get in a car and start it and, you know, these cars, you just touch them.

And so then I say, 'Well, then, I'll try to find out. Maybe the ladies know where the keys are. I

don't know.' And then I will try to run somewhere when I get a chance real quick, let the wife know he is trying to get the keys to the car, so we need to talk to him so we can get him off of that.

01:44:20 **Q.** So, this type of episodes, I mean, are these things that you have seen in other patients that you have previously worked with, with Parkinson's dementia?

A. Yes. Yes.

Q. And do these episodes seem to be happening with more

01:44:33 frequency as time goes on, or less?

A. No. More.

Q. Now, at some point during the time period that you cared for Mr. Brockman, did you learn that the government has taken the position that Mr. Brockman is faking or

01:44:48 exaggerating his symptoms?

A. Yeah. I heard just talk. They really don't let me know a lot of stuff. When they come, they send me sometimes to go to another room or something because they didn't want me to -- they cared for me not to get

01:45:02 involved. And I said, 'No, sure. No problem. I don't have a problem. I'll walk over there.'

But there is -- I heard one time before where they were mentioning about that. She was talking to him. And I can't believe they're doing that, you know,

01:45:12 that they don't believe that and stuff and, so, I -- yeah,

I heard before.

Q. Okay. So when you heard that, did you -- did you think it was possible that Mr. Brockman was faking or exaggerating his symptoms?

01:45:24 **A.** No. No. And what I -- when I heard that, too, I was kind of -- I was a little bit -- I was a little bit worried because I am here to take care of a patient, and if I have somebody that's acting, or some way just to do something for whatever it is they are doing, then, to me 01:45:38 that's -- I don't need to be here in this place. I need to really go where somebody needs my help.

So, when I heard that, I started, like, Oh, my God, is he acting? Is it? So I started kind of keeping more close of him, looking at his -- what he does, 01:45:50 what he's -- see if he's like -- because I feel like if somebody is lying, they can't lie too long. They are going to have to be able -- something comes out that is normal, that's where he is sharp and all that. And so that's what I was looking for, but I never was able to see 01:46:03 anything like that at all.

Q. So, is there any doubt in your mind, Mr. Gutierrez, as you sit here today, that Mr. Brockman's physical symptoms are real?

A. They are. They are real.

01:46:15 **Q.** Same question with respect to his mental

difficulties. Any doubt in your mind that those are real?
A. Yes, sir. They're real. They are so real. I will say something real quick, that they're so real that I get nervous. I am kind of a little bit scared. Because when
01:46:32 they are like that, you don't know what they are going to do. So I just -- I am so afraid that they are going to get hurt or hurt somebody else, especially his wife who is very -- not in really good health right now herself. She is in really bad pain because of back and lower back and
01:46:45 hip, and so I am really real caution about that and so that's why.
Q. All right. I am showing -- going to put on the screen here, Mr. Gutierrez, what is in evidence as Defense Exhibit 72, and I just want to -- I highlighted a few
01:46:59 things here. You have been working with the Brockmans and -- Mr. Brockman since April of this year?
A. Right.
Q. Okay. And so since you -- you began assisting Bob, fair to say there has been a large number of interviews
01:47:17 and tests that have been undertaken by Mr. Brockman in connection with why we're here today?
A. Yes. Yes.
Q. Okay. I have got a few of these highlighted. And I just want to note here on -- on May 5th, first highlighted
01:47:30 mark, did you -- did you assist Mr. Brockman in getting to

the interview with Dr. Darby?

A. Dr. Darby?

Q. On May 5th, the very first one.

A. Oh, yes. Yes. Yes.

01:47:42 **Q.** And that one lasted, I think we have up here, about three hours. When Mr. Brockman would be there for these interviews, would you be present inside the interview room, or be outside available for whenever you were called in to assist Mr. Brockman?

01:47:57 **A.** I would be outside.

Q. Okay. But for this first one on May 5th, you were present and helped Mr. Brockman get there?

A. Right.

Q. And also helped him go to the restroom during the -- you know, in the middle of the interview, is that fair?

01:48:08

A. That's correct.

Q. And then also help him depart the meeting?

A. That's correct. Yes.

Q. At any point on May 5th, did Dr. Darby try to interview you?

01:48:18

A. Darby? No. No.

Q. No? Okay. I am going to ask a series of these same questions. Okay. And I'll do it a little bit faster.

Do you recall May 18th, Dr. Denney and Dr. Dietz interviewed Bob for eight hours at a hotel in

01:48:32

downtown Houston?
A. Yes.
Q. Did you help Mr. Brockman get to that interview, help him during restroom breaks, and then help him depart the
01:48:46 meeting?
A. Yes.
Q. Did Dr. Dietz or Dr. Denney ask to interview you at any point during that time?
A. No.
01:48:52 **Q.** And then on March -- I'm sorry -- May 19th, do you recall that Mr. Brockman again reported for an interview with Dr. Denney that also was around eight hours that following day?
A. Yes.
01:49:05 **Q.** Did Dr. Denney seek to interview you that day?
A. No.
Q. The following day, on May 20th, Dr. Dietz and Dr. Denney were again both interviewing Mr. Brockman, if you will recall?
01:49:17 **A.** Yes.
Q. The same questions. Did you help Mr. Brockman get there, help during breaks and help him depart?
A. Yes.
Q. At any point in those times -- in that time, did
01:49:24 Dr. Dietz or Dr. Denney seek to interview you?

A. No.

Q. And then just moving down to October, the same questions. Do you recall helping Mr. Brockman get to Dr. Dietz and Dr. Denney's interview of him at the Jones Day offices on October 20th?

01:49:38

A. Yes, I did help him.

Q. The same questions. You helped him arrive, helped him during breaks, and helped him depart?

A. Yes.

Q. The same question for October 26, when Dr. Denney came for a follow-up meeting for just about an hour.

01:49:47

A. Yeah, I remember that. Yes.

Q. Okay. The same questions. On the 20th or the 26th, did Dr. Dietz or Dr. Denney ever seek to ask you any questions?

01:50:00

A. No.

Q. Now, in all those instances and interactions, did either of those doctors or any three of the doctors -- set aside interview you -- just ask you questions about how Bob was, what it was like to be with him on a daily basis?

01:50:12

A. No.

Q. Did they ask you any of those questions?

A. No.

Q. Would you have talked to them if they had asked you?

A. Yes.

01:50:19

Q. I just want to ask some final questions here.

I am showing you some testimony from Dr. Darby, who was the first person that, if you'll remember, interviewed Bob.

01:50:37 **A.** Uh-huh.

Q. And I want to just be very clear. As we sit here today and during the time period you have taken care of Mr. Brockman, does he need help with his grooming?

A. Okay. I'm sorry. What was that?

01:50:51 **Q.** During the time -- As you're taking care of Mr. Brockman today --

A. Right.

Q. -- and every day --

A. Right.

01:50:57 **Q.** We have kind of walked through a day. I just want to ask you some specific questions.

-- do you have to assist Mr. Brockman with his grooming?

A. Yes.

01:51:04 **Q.** With grooming his hair --

A. Yes.

Q. -- and shaving?

A. Yes.

Q. And the same thing with his self-care, whether it's, again, shaving or combing his hair --

A. Yes.

Q. -- or getting ready?

A. Yes.

Q. And what about using the restroom?

01:51:17 **A.** Yes.

Q. And then does Mr. Brockman have difficulty remembering where he is?

A. Yes.

Q. And does he also have difficulty recognizing his own

01:51:25 home?

A. Yes.

MR. VARNADO: I am going to pass the witness.

THE COURT: Cross-examination, whenever you are ready.

01:51:34 MR. LANGSTON: Thank you.

CROSS-EXAMINATION

BY MR. LANGSTON:

Q. Good afternoon, Mr. Gutierrez. My name is Lee Langston.

01:51:51 **A.** Yes, sir.

Q. I think you testified you have only known Mr. Brockman since April 15th, 2021?

A. Yes, sir.

Q. And you can't speak to how he was like before that

01:52:05 date; is that fair?

A. That's fair.

Q. Okay. And, so, you don't know what his mental state was on March 1st, 2019?

A. No, sir.

01:52:13 **Q.** You can't talk about it for April 20th -- April of 2020?

A. What --

Q. Of 2020.

A. Oh, sorry. Yeah. No. No, sir.

01:52:23 **Q.** For November of 2020?

A. Right. No.

Q. And I think Mr. Varnado asked you a series of questions about things Mr. Brockman can and can't do; is that fair?

01:52:34 **A.** Yes. That's -- yes.

Q. And some of those were based on physical limitations; is that correct?

A. That's correct.

Q. And some of them are based on mental limitations?

01:52:42 **A.** Yes.

Q. And it's fair to say that those can be different; is that fair?

A. Yes.

Q. That sometimes a patient -- there are certain things

01:52:49 they can't do because physically they can't do it?

A. Right.

Q. And sometimes there are things they can't do because mentally they can't do it?

A. Right.

01:52:55 **Q.** So, simply because someone physically can't do something, that doesn't necessarily mean they can't do it mentally.

A. Right.

Q. Is that fair?

01:53:02 **A.** Right.

Q. And I think you -- you talked a little bit that sometimes -- I think you used the word "they" are talking about his criminal case?

A. I'm sorry? I'm sorry? What?

01:53:15 **Q.** I think I heard on your direct examination that sometimes they would be talking about his criminal case.

A. No.

Q. Okay. Let me ask it this way. Are there sometimes meetings that Mr. Brockman has with his attorneys?

01:53:29 **A.** Yes.

Q. Okay. And do you go into the room with them?

A. No.

Q. Okay. So, you don't know what's discussed inside those meetings.

01:53:35 **A.** No.

Q. Is that fair?

A. That's fair.

Q. And I think you talked, when you said you learned that the government may be accusing him of faking -- Do you remember discussing that?

01:53:44

A. Yeah. Only through -- the wife was talking to him, because -- that -- just to him, real low, and I just happen to heard a little bit of that, yeah.

Q. Okay. And, so, sometimes Mrs. Brockman and Mr. Brockman will have discussions, and you don't want to invade their privacy; is that fair?

01:53:55

A. That's -- yes.

Q. So, you may pick up little bits and pieces here and there, but, by and large, you try to let them have those conversations privately; is that fair?

01:54:07

A. Most of the time they do have it privately. Even the phone calls, because she will tell me, you know, to -- 'Frank, do you want to go ahead and' -- or they will go to the office a lot. That's where they have their calls there or talk to people, yeah.

01:54:18

Q. So, sometimes there will be phone calls and they will say, you know, 'We'll handle this one without you.'

A. Yes.

Q. Is that fair?

A. Yes. Actually, what I do is I help him -- like I

01:54:24

said, because they want to have it somewhere where he is safe, so -- Most of the time it's in the office. So, I will walk him into the office to have those phone calls or the Zooms and all that. So, I will set him there with a
01:54:38 bottle of water and then close the door, and then I go all the way to the kitchen while they're way back there, over there.

Q. Okay. And, so, other than what you may learn later, you don't know what happens on those phone calls or
01:54:48 meetings or anything?

A. No, sir.

Q. And I think you said sometimes Mr. Barras will come visit?

A. Yes.

01:54:53 **Q.** And do you give him privacy during those meetings?

A. Yes.

Q. Okay.

A. Yes.

Q. In -- as part of this case, I think, you were asked a
01:55:03 series of questions about how you didn't speak to the government experts; is that fair?

A. Right.

Q. I think you said it was because they didn't ask.

A. Right.

01:55:10 **Q.** You did speak to one of the defense experts in this

case. Right?

A. I don't remember that.

Q. Did you speak to a Dr. Agronin? Do you remember doing that? He is sitting there in the second row. Does that jog your memory?

A. Oh, yes. Yes. Yes. Yes.

Q. And Dr. Agronin was interviewing about Mr. Brockman's mental competency; is that fair?

A. Yes.

Q. And he wasn't one of Mr. Brockman's treating doctors?

A. No. No. No.

Q. And, so, you understood that he was talking to you to try and make an evaluation of Mr. Brockman for this case; is that fair?

A. It was more just -- it was more like because I walked in, he was getting ready to leave and he just kind of asked me some simple questions right there, just, you know -- nothing like -- you know, he was just talking, asking me questions. That was it. Yeah.

Q. So, it wasn't a formal thing?

A. No, sir.

Q. And I think you gave him his medications, maybe; is that right?

A. To be honest, I can't remember. I know that he was just asking me some simple questions but nothing really

big or anything.
Q. Okay. But he was trying to get a sense for your treatment of Mr. Brockman; is that fair?
A. Yeah.
01:56:25 MR. LANGSTON: Just one minute, Your Honor.
THE COURT: Sure.
BY MR. LANGSTON:
Q. And you told him? You spoke to him about it?
A. Yeah. Yeah, because it was more like -- the way
01:56:40 he -- he talked to me, it was like just a passing. We just -- because they were like he was done. And, so, really, I didn't take really full thought of what it -- you know.
Q. Sure. Now, I am going to show you what I am going to
01:56:53 mark for identification as 160 --
A. Uh-huh.
Q. -- Government's Exhibit 160.
MR. LANGSTON: Now, I'll hand a copy to the witness.
01:57:04 **A.** Thank you.
BY MR. LANGSTON:
Q. And these are notes that Mr. Agronin took about his interview.
A. Uh-huh.
01:57:17 **Q.** Did he ever show this to you?

A. No.
Q. Okay. And have you ever seen this before?
A. No.
Q. All right. But the list of medications there, is
01:57:26 that the list of the medications as of October of 2021?
A. Yes.
Q. Okay. And I want to look at the first two sentences.
A. Uh-huh.
Q. "Frank Gutierrez, a personal aide to Robert Brockman.
01:57:55 He has worked with Mr. Brockman for the past year-plus and has seen him slowly but steadily decline physically and mentally."
This was -- you talked to him in October of 2021?
01:58:09 **A.** Yes. Somewhere around there, yeah.
Q. And I think you -- as you have said, you only worked with Mr. Brockman since April?
A. Right.
Q. So, about five months at that point? Six months?
01:58:19 **A.** Yes. Yes.
Q. Okay. So, it's fair to say you hadn't worked with him for a year --
A. No.
Q. -- plus?
01:58:24 **A.** No.

Q. And, so, Dr. Agronin probably just got that wrong?
A. Yes. Yes.
Q. Okay.

MR. LANGSTON: I'll offer 160, Your Honor.
01:58:31 MR. VARNADO: No objection.
THE COURT: Without objection, 160 is admitted.
MR. LANGSTON: And no further questions.
MR. VARNADO: No further questions, Your Honor.
THE COURT: May this witness be excused?
01:58:38 MR. VARNADO: Yes, he can.
THE COURT: Thank you, Mr. Gutierrez.
THE WITNESS: Thank you, sir.
MR. LOONAM: Next witness?
THE COURT: You may call your next witness.
01:58:53 MR. LOONAM: Your Honor, we call Dr. Thomas Guilmette.
THE COURT: Good afternoon, sir. If you could raise your right hand -- well, juggle there -- raise your right hand.
01:59:06 (Witness sworn.)
THE WITNESS: I do.
THE COURT: Please take the stand, sir.
THE WITNESS: Thank you.
THE COURT: And you may take your mask off if
01:59:27 you wish.

THE WITNESS: Okay. Thank you.

THE COURT: It's not a problem.

THOMAS GUILMETTE, Ph.D.,

duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. LOONAM:

Q. Good afternoon, Dr. Guilmette.

A. Good afternoon.

Q. Please state and spell your last name for the court reporter.

A. Thomas Guilmette. G-U-I-L-M-E-T-T-E.

Q. And what do you do for a living?

A. I am a psychologist.

Q. And where do you work?

A. I am a professor of psychology at Providence College, in Providence, Rhode Island, and also an adjunct associate professor of psychiatry and human behavior at Brown University Medical School. And I also work in a private practice where I see patients, and I also do some forensic consultation.

Q. All right. Can you walk us through your educational background.

A. I graduated with a bachelor's degree in psychology from Providence College. I received my Ph.D. in counseling psychology from the University of Missouri in

Columbia, Missouri. I completed a clinical psychology internship at Walter Reed Army Medical Center in Washington, D.C. And I completed a two-year postdoctoral fellowship in clinical neuropsychology at Rhode Island
02:01:13 Hospital and Brown University School of Medicine.

Q. All right. And can you walk us through the history of your clinical work?

A. You mean the jobs that I have had clinically?

Q. Yes.

02:01:22 **A.** Okay. My first job after my internship, I was an Army psychologist, and I worked at the Army hospital at the United States Military Academy at West Point, New York. I then did my two-year postdoctoral fellowship. After that I became clinical director of neuropsychology
02:01:41 at the Vanderbilt Rehabilitation Center in Newport Hospital. I then worked from -- that was from '86 to '90.

From '90 to '97 I was director of neuropsychology at Rhode Island Hospital. I also consulted at some local rehabilitation centers, hospitals
02:02:00 as well.

I was in private practice for a year from '97 to '98. In 1998 I joined the faculty at Providence College and also continued to do consulting at local hospitals.

02:02:13 **Q.** Okay. And can you describe the different teaching

positions that you have held?

A. Well, I have been an adjunct faculty member at C.W. Post University in New York. I have been an adjunct faculty at the University of Rhode Island. And my -- my primary teaching job is at Providence College, and I also teach seminars at Brown Medical School to the neuropsychology residents and fellows.

Q. All right. And are you board-certified?

A. I am in clinical neuropsychology.

Q. Clinical neuropsychology. What is that?

A. Neuropsychology is, essentially, the study of brain function through behavioral and psychological tests. So, it's the relationship between brain and behavior.

Q. All right. And are you board-certified in forensic psychology?

A. I am not.

Q. Do you have experience in forensic psychology?

A. Yes, I do.

Q. Can you describe that to the Court?

A. Well, I have some research and academic experience there. I have -- I have done research in malingering and malingering detection. I have co-authored a book chapter in the *American Psychological Association Handbook of Forensic Psychology*.

I have -- I teach a course in psychology

and law at Providence College. I also teach a seminar in forensic neuropsychology to the Brown neuropsychology postdocs and fellows. I -- and I have been involved in forensic consultation of various types over the years.

02:03:59 **Q.** And have you been -- have you acted as -- well, an expert witness in -- in court cases before?

A. Yes, I have.

Q. And have you been qualified as an expert and testified in court?

02:04:10 **A.** Yes, I have.

MR. LOONAM: Your Honor, at this time we move to recognize the witness as an expert in forensic psychology and neuropsychology.

THE COURT: He is so recognized.

02:04:31 BY MR. LOONAM:

Q. You conducted an examination -- or more than one examination of the defendant, Bob Brockman, in this case. Correct?

A. Yes.

02:04:40 **Q.** And did you do that in connection with what's known as "The Forensic Panel"?

A. Yes.

Q. What is The Forensic Panel?

A. The Forensic Panel is a national medical and forensic

02:04:53 sciences practice.

Q. Okay. And can you describe your work for The Forensic Panel?

A. On this case or just in general?

Q. In general.

02:05:01 **A.** In general. So, I have worked with The Forensic Panel on a few different cases, either as what's called a primary examiner, someone who actually would evaluate the plaintiff or a defendant, or as a consultant, a peer reviewer where I would be part of a group of

02:05:23 neuropsychologists who might help to advise a primary examiner. And I have also done research on a topic that might be of interest to The Forensic Panel.

Q. All right. And in connection with this case, did you work together with other experts?

02:05:37 **A.** Yes, I did.

Q. Okay. And who did you work with?

A. So, the other experts that I worked with that were involved in the actual evaluation are Dr. Agronin, Dr. Wisniewski, Dr. Whitlow, and then there were other

02:05:53 consultants in this case, neuropsychologists, Dr. Seward, Dr. Marcopolis and Dr. Goldberg, and then also Dr. Welner.

Q. Okay. Let's go through -- So, when it comes to those doctors that actually conducted the examination -- I think you described them as the primary examiner; is that

02:06:16 correct?

A. Yes. They would -- Right, the actual -- the -- the specialists who actually evaluated Mr. Brockman.

Q. Okay. And I think you described Drs. Agronin, Wisniewski and Whitlow. What roles did they play in connection with the examination of the defendant, Bob Brockman?

02:06:34

A. So Dr. Agronin is a specialist in geriatric psychiatry. So, that is his area of specialty.

Dr. Wisniewski -- I am not saying his name properly. It's --

02:06:48

Q. That's okay.

A. Dr. Wisniewski --

Q. I'd give it to you, but I can't lead.

A. -- fair enough -- is a neurologist with expertise in dementing disorders. Dr. Whitlow is a neuroradiologist.

02:07:02

Q. All right. And you mentioned that Dr. Agronin was a geriatric psychiatrist. What's that?

A. So, he has particular expertise in psychiatric illness of older adults.

Q. And was it important to you that this case had a geriatric psychiatrist conduct or participate in the primary evaluation of Mr. Brockman?

02:07:18

A. Yes.

Q. Why?

A. Well, because, first of all, Mr. Brockman is an older

02:07:31

adult. And we're talking about a question of his mental capabilities and the possibility of a dementing disorder. Dr. Agronin sees those patients all the time. So, he would have particular expertise in the assessment of someone of Mr. Brockman's age and their mental state and other potential psychiatric illnesses that he might be suffering from.

02:07:53

Q. All right. And do you know how much you're paid for your work in this case?

02:08:06

A. Yes.

Q. How much?

A. I am paid $325 an hour.

Q. $325 an hour. And do you have a ballpark of how much total you're owed on this case? How much you have been paid and like what the grand total would be to date.

02:08:20

A. I don't know. I would guess somewhere around 70- or $80,000.

Q. Okay. We'd have to do the math to figure out how many hours that is.

02:08:34

A. I don't -- A lot of hours.

Q. Yes. Okay.

Oh, and to close the loop, for the other professionals who act as sort of the consultants -- the peer reviewers, you called them, can you describe the role they play in The Forensic Panel's process?

02:08:48

A. Yes. So, before I would go to evaluate the defendant, I would have a -- or there would be a conference call with the primary examiners as well as the reviewers, and we would go over the case and talk about the case.

I discuss the clinical and forensic aspects of the case. And they would help me -- they may make suggestions about my clinical assessment, hypotheses to consider, and I would incorporate that feedback into the -- into the assessment instruments that I chose to administer to Mr. Brockman and in my approach to the evaluation.

Q. And whose ultimate choice is it how you conduct your examination?

A. Well, it is ultimately mine.

Q. Yeah. And the opinions you have offered here, whose are they?

A. They are mine.

Q. Okay. What was the purpose of the examination?

A. The purpose of the examination was to determine if Mr. Brockman suffered from a mental disorder and, if so, would it affect his ability -- and would it affect his competence to stand trial.

Q. All right. And were there particular questions that were put to you in connection with your examination?

A. Yes.
Q. And are those -- were those questions reflected in your expert report?
A. Yes.
02:10:26 **Q.** All right.
MR. LOONAM: I'm going to -- DX-22.
You don't need a copy of this, do you? Here. I have it here. Save you the trouble.
BY MR. LOONAM:
02:10:47 **Q.** DX-22. All right. Are you able to see those questions?
A. Yes.
Q. All right. Will you read them to the Court?
A. "What does the data collected to date reflect upon
02:11:00 the nature of Robert Brockman's neuropsychological impairment?
What diagnoses are reflected in the recent history and current neuropsychological testing?
Is Mr. Brockman able, given the nature of
02:11:11 the charges against him, to assist his attorneys with relevant requested facts, dates, and details?
Based on his performance in the testing, does Mr. Brockman demonstrate the mental stamina needed for a courtroom trial on the charges he faces?
02:11:26 Is Mr. Brockman able to assist his counsel

in defending his case? Why or why not?

Does the evidence reflect that Mr. Brockman is malingering cognitive incapacitation?"

Q. Okay. And we will come back to these questions and answer them in more detail.

But can you just give us your sort of top line conclusions that you have reached after your examination of Mr. Brockman?

A. Yes. I am of the opinion that Mr. Brockman suffers from dementia and that his dementia negatively affects his ability to assist his lawyers in his own defense.

Q. And when you say "negatively affects his ability to assist his lawyers in his own defense," can you provide some details to the Court on what you mean by "negatively affects?"

A. That he is unable to provide, with a reasonable degree of rational understanding, information that will assist his lawyers in his own defense.

Q. Okay. And then is -- the language you are using there, is that -- is that a particular standard that you're referencing?

A. Well, it is, as I understand it, the Dusky Standard.

Q. And what is the Dusky Standard?

A. The Dusky Standard is relevant to whether a defendant has the ability to consult with his attorney with a

reasonable degree of rational understanding, and whether he has a rational as well as factual understanding of the proceedings against him.

Q. And as far as you observed, what part of the Dusky Standard do you believe is really at issue in this case?

A. The first one, the issue of his ability to consult with his attorney with a reasonable degree of rational understanding.

Q. Okay. Are you aware of different cognitive domains?

A. Yes.

Q. And what are the different cognitive domains?

A. Well, it depends upon how you want to slice up the pie, so to speak. But generally speaking we talk about things like attention. One's ability to simply attend to information that's happening in the environment, and to block out information that's not relevant.

Working memory, which is the ability to keep something in your head at any given moment, and then to perform some mental operation on it.

We think about mental processing speed, how rapidly someone is able to think through problems and process information.

Certainly memory and learning, how well a person is able to absorb new information, retain it, and then recall it later.

Visual spacial function, how well someone is able to, for example, navigate their physical world.

Problem solving and judgment, which are also part of a group of skills called executive functions, that have to do with how well someone is able to regulate their behavior, organize themselves, plan, use problem solving strategies to get to a desired endpoint. It also involves things like motivation and perseverance.

Q. And with respect to your top line conclusions, and we will drill down into these, which of these cognitive domains do you believe are impaired with respect to Mr. Brockman?

A. I think all of them are. Excuse me. I also should add -- I didn't mention language functions. I should have mentioned language functions, that's one of the major cognitive domains. And, however, language functions are an area that still seem to be a relative strength with Mr. Brockman.

So certainly his attention, his working memory, his processing speed, his memory and learning, and his executive functions are all areas that would adversely affect his ability to participate in his own defense.

Q. Okay. And you mentioned that language function is relatively preserved. You know, based on what you observed with respect to how the cognitive domains of

Mr. Brockman have been impaired, do you have, you know, a -- a belief with respect to what type of dementia you believe Mr. Brockman is suffering from?

A. I believe that his clinical presentation or his neuropsychological test data or profile at this point are most consistent with Parkinson's disease dementia.

Q. All right. And in addition to Parkinson's disease dementia, do you believe that there may be a -- a coexisting diagnosis?

A. It certainly is quite possible, yes.

Q. And what is that?

A. Alzheimer's disease.

Q. And prior to conducting your examinations of Mr. Brockman, did you review materials in connection with this case?

A. Yes, I did.

Q. And what types of materials did you review?

A. I reviewed medical records. I reviewed e-mails. I reviewed testimony. I reviewed prior neuropsychological test results. I -- there were hundreds of documents.

Q. Okay. And can you describe for the Court just generally the categories of information you relied on to reach your opinion?

A. Well -- well, I relied certainly on his medical records, reports from physicians, the neurodiagnostic

studies, reports of other neuropsychological test results. I also relied on some collateral information from Mrs. Brockman and from others, and then certainly my own test results and observations of Mr. Brockman.

02:17:59

Q. Okay. And then I don't know if I -- if I heard or not, but are you familiar with whether or not there was any neuroimaging done on Mr. Brockman?

A. Yes. I had -- right. Yes. But I also mentioned the -- the neuroimaging that was conducted was also part of what I reviewed.

02:18:13

Q. Okay. And when did you conduct your examinations of Mr. Brockman?

A. The first time I saw him was in July. I think the 13th and 14th of July. And the second time was October 2nd.

02:18:28

Q. Okay. So July 2021 and October 2021?

A. Yes.

Q. Okay. All right. You testified that part of your opinion is based in part on neuropsychological testing conducted by others and neuropsychological testing that you conducted, is that accurate?

02:18:45

A. Yes.

Q. Can you describe for the Court just generally what neuropsychological testing is?

02:18:59

A. Sure. So, neuropsychological testing really is composed of a series of mental tasks that we ask patients to do. Some are strictly verbal, asking them questions, asking them to memorize a list of words. Some are paper and pencil. Some are computer administered. But they are designed to assess various aspects of thinking skills in an individual.

Q. Okay. And when -- you know, when are these typically administered, like what are these used for?

02:19:33 **A.** Oh, so they're used clinically for patients where there is either a question of some cognitive impairment, whether due to, let's say, normal aging or some degenerative disorder like dementia, or it can be due to a question of someone has sustained a brain injury from a

02:19:54 concussion, or from a car accident, or from a brain tumor, or cognitive impairments from a psychiatric illness.

Sometimes we know a patient has brain damage because they have been in a coma for two weeks, and so sometimes the evaluation is to determine what's the

02:20:13 nature and severity of the deficit and how much do the impairments affect the person's ability to, let's say, go back to work, or go back to school, handle their finances, things like that.

Q. And, you know, in the context of diagnosing a

02:20:32 cognitive impairment, are there occasions when you have to

take -- well, do you always have to take into account the risk of secondary gain?

A. Yes, when present.

Q. Okay. And what is that?

02:20:42 **A.** Secondary gain is motivation for someone to either create or exaggerate impairment, either for some gain, financial gain, let's say, or to avoid some aversive event, like military service or prison.

Q. Yeah. Or criminal prosecution?

02:21:06 **A.** Yes.

Q. So, for example, in this case, this is a clear case where there is secondary gain present at the time of your examination, correct?

A. Oh, yes.

02:21:19 **Q.** How do the tests account for the risk of secondary gain and somebody just faking it?

A. How do the tests in general?

Q. Well, yeah, do the tests in general account for it and have some tests, you know, developed, you know, 02:21:35 specific mechanisms to try and catch the fakers?

A. Yes. So, some tests have built-in safeguards where there are certain indicators within a test that tell us that individuals even with severe brain damage do well on this kind of test.

02:21:52 And then there are other tests that are --

that have been created specifically to try to detect people who might be trying to fake brain damage.

Then there are other tests that we give that are -- that don't play any specific role in the
02:22:08 detection of poor effort, or trying to assess for secondary gain.

Q. Okay. And are you familiar with -- with what I'll call the Green tests?

A. Yes.

02:22:19 **Q.** I mean, what are the Green tests?

A. So the Green tests are three different tests of validity. They are computer-administered. One is called the Word Memory Test, one is called the Nonverbal Medical Symptom Validity Test, and the third is simply the Medical
02:22:40 Symptom Validity Test.

And these are three, as I said, computer-administered measures that were designed and created specifically to try to detect people who might be trying to fake especially a memory deficit or memory
02:22:53 impairment.

Q. Okay. Now, on -- with respect to these tests, is there a challenge in connection with administering these tests, in a -- an elderly population?

A. Yes.

02:23:08 **Q.** Okay. Can you describe that to the Court?

A. Yes. So early on in the development of these tests, they were given largely to help to try to identify people who were trying to fake brain damage from a concussion for a mild brain injury, and so we gathered a lot of data, 02:23:27 "we" meaning the field, gathered a lot of data on patients who had sustained a concussion or maybe a moderate to severe brain injury and we would give them these tests and see how they would perform.

And they're relatively easy tests to do 02:23:40 for the most part and so the test developers presume that, well, because they're easy to do, we can give these to anyone who we think might be faking brain damage and they should all do well on them.

However, as we began to give them to 02:23:53 special populations, like individuals with very low IQ, or individuals who were much older, or patients with dementia, we found that -- in fact that many of these tests were failed by older adults and by patients with dementia and by patients with low IQs.

02:24:10 So, what was happening then, was that there was a recognition that these tests were generating what we call false positive errors, meaning identifying someone as producing an invalid test profile because they weren't trying hard enough, or they were trying to fake 02:24:24 brain damage, when in fact they were failing because they

were so impaired.

Q. Well, a couple of questions from that.

So, first, this isn't the time to be modest. You said "the field." Did you participate in the -- the early days of developing these -- these sort of validity tests to check the validity of neuropsychological testing?

A. Yes.

Q. And did you even develop your own test at one point?

A. Yes, I did, although it didn't get very far.

Q. Okay. Okay. And you said that, you know, they were failing the tests because they were so impaired.

Can you describe to the Court some of the reasons why, you know, someone might receive an invalid score, and -- other than they're exaggerating their symptoms?

A. Oh, yes. So sometimes patients will -- will -- will produce a score that is in the invalid range, meaning that we think that the performance is not valid. It doesn't accurately reflect their abilities.

And sometimes it's due to a lack of effort or sometimes it's due to trying to fake brain damage. Sometimes it's due because the patient is too tired, exhausted. They're having a bad day. They are just not engaged in the testing. They are angry to have to be

tested, some especially older adults who might not want to be exposed as having some impairment. They may be very resistant to testing and so when you try to test them, they just sort of -- they give up quickly. They don't
02:26:23 care. They don't try. And so you can get a failure on these validity tests for reasons other than the fact that someone is intentionally trying to do poorly for some other -- for some secondary gain purpose.

Q. Understood. And you described before that there is a
02:26:40 challenge administering these tests to patients with dementia.

Can you just describe that in a little more detail, what the challenge is with respect to administering these tests with patients with dementia?

02:26:52 **A.** Well, sometimes it is difficult just to engage them in the testing process. Sometimes older adults when they are referred for dementia evaluations, they -- they don't always appreciate the nature of their deficits. They feel embarrassed, humiliated, and so sometimes it is difficult
02:27:08 just to engage them in testing.

At other times, though, even for those patients who are engaged in testing, the test is just too hard. So they get an invalid score because the test doesn't always discriminate well among those people who
02:27:26 are really impaired and those who are only mildly or

moderately impaired, and so they can appear, based on the test results, to be producing an invalid profile, that then becomes a chore for the examiner to determine whether or not is this low score on this validity test low because
02:27:50 a person is trying to fake brain damage or is it low because they actually are impaired?

Q. Okay. And let's cover the Green tests first. Did the Green tests on -- have a mechanism to identify those individuals, or to attempt to identify those individuals
02:28:10 with dementia who are having low scores, as opposed to the fakers who have low scores?

A. Yes. Yes.

Q. And what is that mechanism?

A. Well, and so to the credit of the Green tests, there
02:28:25 are mathematical formula built into each of the Green tests, that if a person fails, that is get a score below the cutoff, their test scores are analyzed by a computer program that will then determine whether or not this profile is reflective of a possible genuine memory
02:28:47 impairment, meaning this is how dementia patients can perform, or is this profile due to someone who was likely simulating or faking brain damage.

Q. Okay. And are you familiar with any research about the sensitivity of the Green tests in detecting the fakers
02:29:12 versus those who have, you know, genuine memory

impairment?
A. Well, certainly, the -- there are -- to -- so the -- the Green tests, when you asked, for example, individuals to simulate brain damage on the Green tests, depending on
02:29:36 how many of the Green tests you give, then the Green tests can be quite good at identifying individuals who are trying to fake brain damage from those who actually have genuine memory impairment.
Q. And when you say you give them a combination, you
02:29:53 know, the particular study, if you give the three Green tests in one sitting, and -- are the fakers able to generate a genuine memory impairment profile across all three tests?
A. No. No. Even individuals -- graduate students, for
02:30:16 example, in psychology who were asked to fake dementia on the Green tests were -- no one was able to fake dementia across all three of the Green tests.
Q. Okay. Now, for -- the tests other than the Green tests, there are a whole battery of validity tests that
02:30:37 are not the Green tests, correct?
A. Oh, yes.
Q. And we are going to discuss them all here today, but, you know, what are some of the ways you can account for the possibility that somebody is suffering from dementia
02:30:49 in administering those other tests that don't have the

sort of mathematical algorithm to try and identify the genuine memory impairment issue?

A. Well, if I -- if I understand correctly, then one needs to calibrate differently the cutoff scores for these tests for information that we have with -- with known dementia patients who are believed to have been putting forth adequate effort on measures, and so then we would need to change the cutoff scores to accommodate older individuals who have a much higher rate of failure than younger individuals, and older individuals with dementia who have a much higher rate of failure than individuals without dementia.

So we are -- we need to make that -- we need to change the calibration of what we consider to be cutoff.

Q. And as a baseline, how are those tests typically calibrated? What's the pool of folks that are setting the sort of default baseline for those validity tests?

A. Generally, they are not -- although more have been recently, but generally they are not individuals with dementia. That is not who they tend to be given to for the most part.

There have been some studies that have certainly -- and so that's very helpful to help us understand what kind of a normal range of scores is on

these measures. But, historically, the normative data on many of these tests have been for -- with middle-aged adults, or individuals with more moderate to severe traumatic brain injuries rather than dementia.

02:32:33 **Q.** Okay. And so what do you do to the cutoff scores to adjust them, to account for the possibility that you're administering the test to a dementia patient?

A. Well, you -- you typically have to then lower the score.

02:32:49 **Q.** And that -- I mean, to translate that, does that mean you make it easier?

A. You don't make the test easier. You make the -- the cutoff point for invalidity lower.

Q. Okay. Yeah. It's like -- you know, like -- like a

02:33:09 -- my kid has a spelling test and you have to get seven out of ten to pass, right? You would change it to make it six out of ten to pass?

A. So, maybe if your child has a learning disability, then you would maybe not want to have his score be

02:33:25 different from kids without a learning disability, so in your analogy that's the way I would see it.

Q. Okay. And were there batteries of neuropsychological testing administered to Mr. Brockman throughout the pendency of this case?

02:33:46 **A.** I'm sorry, "were?" Sorry.

Q. Yeah. Well, how many different neuropsychological testing -- scratch that.

You conducted neuropsychological testing on Mr. Brockman, correct?

02:33:58 **A.** Yes.

Q. Who else conducted neuropsychological testing on Mr. Brockman?

A. Dr. Denney and Dr. York.

Q. Okay. And who was first in time?

02:34:09 **A.** Dr. York.

Q. Okay. Can you describe the -- the neuropsychological -- let's put it this way.

Across all the neuropsychological testing that Dr. York conducted, that Dr. Denney conducted, that

02:34:26 you conducted, can you describe for us what that testing showed about Bob's cognitive functioning and his impairment, if any?

A. Yes. So, essentially the -- the neuropsychological testing across multiple testing sessions revealed that

02:34:46 Mr. Brockman's performance on the majority of measures of mental abilities fell well below the average range.

Q. Okay. And, I guess, in connection with sort of the tests across time, doing a longitudinal analysis, do you see any progression with respect to his testing scores?

02:35:14 **A.** Yes. I mean, it's not necessarily easy because

everybody doesn't give the same test.

So, it is not as if he had the same battery across every single measure, but there were some measures that -- that were more commonly given.

02:35:30 Having said that, from my perspective, I thought that from the early neuropsychological measures to the later ones, Mr. Brockman was showing a decline, especially with his mental processing speed, with his mental stamina, and with his sustained attention.

02:35:49 **Q.** Okay. And was there an area where he was consistently poor?

A. His memory was consistently poor. His digital spacial skills were consistently poor. His language functions though, again, especially his naming abilities,

02:36:05 his vocabulary remained consistently good.

Q. Okay. So, then, I guess, if Mr. Brockman's scores are valid, in the context of the other information available to you, what does that mean? What does that mean to you? What's your opinion with respect to his

02:36:32 competence to stand trial?

A. Well, so, with the level of impairment that he demonstrates, that in my opinion would make it -- he would be unable to assist his lawyer in his own defense with any rational understanding of the information that he had to

02:36:57 help them with.

Q. And, so, then, let's focus on the validity tests, then, that were administered over time for Mr. Brockman.

Did Dr. York -- well, who is Dr. York?

A. Dr. York is a neuropsychologist at the Baylor College of Medicine.

Q. And did Dr. York administer validity tests during her neuropsychological testing?

A. Yes.

Q. And do you recall which validity tests she administered?

A. Dr. York saw Mr. Brockman three times. She administered the Reliable Digit Span, all three times, and on the second evaluation she also administered another validity measure called the Rey-15 Item Test.

Q. And what is the Reliable Digit Span, performance validity test?

A. That has to do with how many digits you can repeat consistently in forward and backward order, and you essentially add up the number of digits in forward order that you can recite consistently and the number of digits backward you can recite consistently and that sum is called the Reliable Digit Span.

Q. And do you recall approximately when the first time Dr. York examined Mr. Brockman?

A. March of 2019.

Q. Okay. And -- and how did Mr. Brockman do on that performance validity test?
A. His performance fell in the valid range.
Q. The valid range. He passed?
02:38:32 **A.** Yes.
Q. And what does that -- what does that mean? Is that -- with respect to his effort that he is putting forth?
A. Well, that means that at least on that measure, his performance was considered to be valid. There was no
02:38:48 evidence of excessive impairment or deficit that would render the test results invalid.
Q. Okay. You had also mentioned -- well, do you know the next time that Mr. Brockman was examined by Dr. York?
A. December 2019. Or October.
02:39:08 **Q.** October 2020?
A. No. No, because it was March 2019, the first evaluation. The second evaluation -- I think that was December of 2019.
Q. December -- that's right. December 2019 is correct.
02:39:22 I'm sorry. So there is -- and you issued the Rey-15 test?
A. The Rey 15-Item Test.
Q. What is that?
A. That's another validity measure in which someone is shown a -- 15 stimuli, asked to memorize them. They are
02:39:37 put away, and then they are asked to draw as many of them

as they can.
Q. Okay. And how did Mr. Brockman do on the Rey 15-Item Test when administered by Dr. York at Baylor University?
A. He also passed it at that -- Wait. I shouldn't say "he also." He passed it at that time.
02:39:51
Q. And was there -- you know, is there an optional component to the Rey 15-Item Test?
A. Yes. There is also a -- a recognition component, which Dr. York did not administer.
Q. Okay. And what's the significance of that, the fact that she didn't administer the recognition piece of it?
02:40:03
A. Well, I think that now the recognition part -- portion -- The original Rey-15 test was just those 15 items that you would show someone and then take it away and then have them draw it from memory.
02:40:20
One of the problems with that measure was that people with real brain damage were failing it. So, a researcher added a recognition component because that added -- that allowed a patient who may have not done as well on the recall portion to do better on the recognition portion. We know that brain-damaged people generally do better with recognition. So, this was trying to eliminate the false positive errors, that is, calling someone a malingerer when, in fact, they are not.
02:40:41
02:40:55
Q. Understood. And -- and then during that same

December examination, did Dr. York again administer the Reliable Digit Span?

A. Yes, she did.

Q. And how did Mr. Brockman do?

02:41:08 **A.** Mr. Brockman passed it.

Q. Okay. And then was there another test that -- that, I had, jumps to in October?

A. Yes, October 20.

Q. Yeah. And did Dr. York administer a performance

02:41:25 validity test then?

A. Yes.

Q. And how did he do?

A. She administered again the Reliable Digit Span, in which Mr. Brockman passed.

02:41:33 **Q.** Okay. Now, can you -- do you have -- do you have a view of Dr. York's -- well, did -- is this a sufficient number of validity tests to conduct a forensic examination?

A. No.

02:41:59 **Q.** Why not?

A. Because when -- in a forensic evaluation there is more of a risk for trying to exaggerate or embellish or fake deficits. And, so, multiple performance validity tests should be given and are given in forensic -- in

02:42:22 forensic-related examinations.

Q. Okay. And did you -- did you just accept Dr. York's findings at face value?

A. What do you mean by that?

Q. Did you just, you know, adopt and accept her testing as -- you know, without a critical eye?

A. No. I mean, they are -- they are data points. There are some problems with her validity testing, especially, because her last two evaluations, she described them as forensic evaluations. So, she did not administer the appropriate number of performance validity tests, and so -- so, it's -- it's data, but it's also flawed data.

Q. Okay. I am going to direct you to Page 22 of your report. You don't need to pull it out. I am going to pull it up on the ELMO.

MR. LANGSTON: Do you want a copy or are you good?

MR. SMITH: No. I got it.

BY MR. LOONAM:

Q. Okay. DX-19. Okay. It's your original report. And I am going to direct you to this paragraph here, and what are you saying in this paragraph here?

A. Well, I am, again, saying that, in forensic evaluations, Dr. York administered essentially just two performance validity indicators, and she should have administered more than that.

Q. Okay. So, to the extent somebody testified in this court that you accepted Dr. York's tests at face value and didn't -- without criticism, that would be incorrect?

A. Correct.

02:44:15 MR. LOONAM: Your Honor, I don't know when is a good time to break. I can go for a while. But whatever --

THE COURT: I know we have been going for an hour and 45 minutes.

MR. LANGSTON: I am happy to go.

02:44:24 THE COURT: Well, let's go ahead and take our break now, then. We will be back at 3:00 and then we will push on.

MS. LOONAM: Sure.

THE COURT: I don't have anything this

02:44:31 afternoon, so we can keep rolling.

MR. LANGSTON: Yes, sir. Great.

THE COURT: Let's take a break until around 3:00, thereabouts.

(Proceedings recessed from 2:44 p.m. to 3:15 p.m.)

03:15:41 THE COURT: You may continue.

MR. LOONAM: Thank you, Your Honor.

Can we switch over to the screen? I am going to go back and forth, but just trying -- I'm going to help -- there's a lot of tests, so to help keep us

03:15:51 organized.

BY MR. LOONAM:

Q. So, these are the Dr. York performance validity test results that you just testified to. Right, Doctor?

A. Yes.

03:16:00 **Q.** So, the Reliable Digit Span in March of 2019; the Rey-15 test without recognition on December 3rd, 2019; the Reliable Digit Span on December 3rd, 2019; and the Reliable Digit Span on October 7th, 2020. Correct?

A. Yes.

03:16:19 **Q.** Okay. And, as you testified before, in the context of a forensic examination, that's not a sufficient number of validity tests. Correct?

A. Correct.

Q. The next battery of neuropsychological testing was

03:16:41 conducted by whom?

A. Dr. Denney.

Q. Do you recall approximately when that was?

A. May.

Q. Okay. There is too much there. Let me go back.

03:16:54 Okay. And do you know -- do you recall which tests Dr. Denney administered?

A. He administered the Word Memory Test. He administered, I believe, the Nonverbal Medical Symptom Validity Test, Reliable Digit Span, Victoria Symptom

03:17:20 Validity Test. He administered a clinical test called

"Sentence Repetition" that includes an embedded validity test, although he didn't count it as such, but -- Perhaps he didn't know about it or -- I'm not sure what. But, anyway, there is an embedded validity test in the Sentence
03:17:36 Repetition test.

And he also administered the Denney competency related test, which he did not identify as a validity measure, but its structure -- it's, I think, 114 items with a forced-choice format, meaning that an
03:17:59 examinee has to respond with either one answer or the other. And the forced-choice format is very common among performance validity tests because it forces someone to make a choice, and if you look at the choices that they make over the course of several trials you can determine
03:18:18 if -- what's the probability of someone getting that score based on chance alone.

So, it's -- even though Dr. Denney didn't describe it as a performance validity test, certainly in format it presents as such, from my perspective.

03:18:36 **Q.** Okay. And when you have a forced-choice validity test, can you describe for the Court sort of the three options that exist as the results of that test.

A. Well, so, a -- a forced-choice validity test means that you give someone an option of -- you're testing,
03:18:55 typically, their memory. And, so, you may say, so, I --

so, I just put my pen in my hand, or a pencil, and you hide it from the person, and then you have them count, and then you say, 'Now, did I hide the pen or the pencil?' And, so, the idea is that, for someone who truly has a severe memory disorder, they should get around chance. If they get significantly less than chance, then the theory is that the person knew the right answer, but they gave the wrong answer.

And so -- and then there are various cutoffs that have been established that are above chance but that are typically obtained by individuals even with memory impairment.

Q. Okay. And, so, I think that covers the list you just described for us.

The Reliable Digit Span performance validity test administered by Dr. Denney in May of 2021, how did Mr. Brockman perform?

A. His score fell in the valid range.

Q. The Sentence Repetition test, what is that?

A. So the Sentence Repetition test is, really, just what it describes. It is a test in which a person is asked to repeat as verbatim, beginning just small phrases, getting longer and longer, more and more words, sentences, longer sentences, and it measures verbal working memory. To be able to repeat a sentence you have to be able to keep the

information in your head and then -- and then spit it back out. And, so, there have been established cutoffs for individuals who are believed to be producing an invalid result on the Sentence Repetition test.

03:20:47 Mr. Brockman's score fell within the valid range.

Q. Now, the Denney competency related test, you said this is a forced-choice test. You consider it sort of -- since it's forced choice, it's -- acts as a validity test.

03:21:04 What's the subject matter of that test?

A. The subject matter of that test is to look at the examinee's legal knowledge, various terms, concepts, really sort of testing their knowledge of the legal system.

03:21:23 **Q.** All right. And how did -- and, so, factual knowledge regarding the legal system?

A. Yes. Where -- excuse me -- where each question has two answers; one is correct and the other is incorrect.

Q. Okay. You know, can you think of an example?

03:21:41 **A.** I, actually -- no, I can't.

Q. Okay.

A. Sorry.

Q. Okay. But -- but related to -- to legal matters?

A. Yes. And, as the title indicates, related to

03:21:54 competency.

Q. Yeah. And how did Mr. Brockman perform on Dr. Denney's designed, you know, competency-related, forced-choice test in May of 2021?

A. Mr. Brockman's -- if memory serves me correctly, he got 87 percent correct.

Q. And so well above chance?

A. Well above chance.

Q. And what's the significance of that for you in evaluating Mr. Brockman's effort level and whether or not he's malingering?

A. So, this test in particular from my -- especially, would really tap into Mr. Brockman's presentation, how he wishes to present himself with regard to his legal knowledge as it relates to his competence.

So, from my perspective, if he is going to try to malinger incompetence to stand trial, this would be an ideal place to do it. For him to able to -- if he were to get a significantly poor score, gets very, very few correct, that would -- on its face validity, would suggest that then he -- how can he be competent because he doesn't know, sort of, the basics of the legal system? But his performance fell well above chance and, in fact, fell generally within the average range. And, so, not only did he pass this as a validity measure, but this is a validity measure that has -- whose content is, from my perspective,

directly related to the issue of competence.

Q. Yeah. And I am making this up. We can go back and get it and you can be crossed on it. But would an example be, you know, 'At the beginning of the case, you're presumed innocent or you're presumed guilty?'

A. That would be the kind of thing.

Q. 'Pick one?'

A. Yes.

Q. So -- Okay. And, so, he got a valid there.

And then there's the Green Word Memory Test. What is Dr. Green's Word Memory Test?

A. That is a computer-administered measure in which an individual is shown 20 word pairs twice. Then the words go away. And then the person is shown on a computer one of the words of the pair and another word that was not on the list. So, that would be a foil. And they have to go through and they have to recognize the words that were on the original list.

Q. Okay. And what was the -- the result obtained by -- well, what was the result obtained -- Well, hold on. Let me do it this way.

I am going to show the witness -- can we go back to the ELMO -- DX-59 in evidence. Here we go. Let me see if I can do a little -- Tell me -- Your screen is different than mine, so you just make sure you can see

that. Okay?
A. Uh-huh.
Q. Are you able to see that?
A. Yes.
03:25:21 **Q.** Okay. And what is this?
A. This is the printout for the Word Memory Test.
Q. And is this the printout for the Word Memory Test administered by Dr. Denney on May 19th, 2021?
A. Yes.
03:25:35 **Q.** Okay. And so just tell us, just generally, what this represents.
A. So, this represents Mr. Brockman's Word Memory Test scores being run through the advanced interpretation software such that Mr. Brockman -- Mr. Brockman's scores
03:25:57 on the subtests that are used to determine whether it's valid or not, fell in the invalid range. So, however, as I mentioned earlier, individuals can perform in the invalid range with a genuine memory impairment.

So, what this shows here is the decision
03:26:13 tree or, actually, the decision tree that the computer is going through, the program is going to -- going through, that identifies that, in fact, that Mr. Brockman did not pass the Word Memory Test, but, upon further examination, the -- his scores on some of the easy subtests and some of
03:26:34 the difficult subtests resulted in what is referred to as

a genuine memory impairment profile.

Q. Okay. And so -- so -- and, you know, when we hear "pass," "fail," "valid," "invalid," at least as a layperson, it triggers a reaction in me that may lead to a misunderstanding; and, so, I want to try and clear that up.

A dementia patient with -- with, you know, moderate dementia, what is the expectation as to what they would score in the valid-invalid range?

A. Well, individuals with dementia are at a much higher risk of failing this test --

Q. Uh-huh.

A. -- failing most tests or, if you will, producing scores that fall in the invalid range.

Q. Uh-huh. And that -- as you testified earlier, is that why Dr. Green developed this possible genuine memory impairment profile, to identify those individuals?

A. Yes.

Q. Okay. And, so, if you go through sort of the decision tree algorithm here -- and then it takes you to two options. What's the option at the top?

A. "Poor effort profile."

Q. Okay. And "poor effort profile," are those the identified fakers?

A. I'm sorry?

Q. Are those the identified fakers?

A. Yes. Yes.

Q. And then below that is what box?

A. The "possible genuine memory impairment."

03:28:07 **Q.** And the fact that it's bolded here, what does that signify?

A. That means that's the -- that's the outcome of the mathematical formula or the mathematical analysis of the results.

03:28:18 **Q.** Okay. And, so, up until this point in the box, is this all sort of computer algorithm that's identifying the possible genuine memory impairment profile?

A. Yes.

Q. Okay. So, there is -- and then after it, the two

03:28:33 boxes after it, are those sort of computer algorithms or are those subjective clinical judgment?

A. So, then the other two boxes, essentially, are -- are referring the -- the clinician, the examiner, to other data that they would need to look at to either confirm or

03:28:56 rule out the possible general memory impairment.

Q. Okay. And what sort of other data do you look at to confirm or rule out the possible genuine memory impairment profile?

A. Well, then you would essentially use your clinical

03:29:13 judgment to -- You would look at medical history. You

would look at other test results. You would look at a person's everyday functional abilities. You would look at neuroimaging data. You would look at all other clinical information to arrive at a conclusion as to whether or not
03:29:33 your opinion would be that this person actually suffers from a possible genuine memory impairment.

Q. Okay. And then the last box talks about, you know, "Interpret relative to appropriate comparison groups." We are going to discuss this in some detail, but can you just
03:29:49 give the Judge sort of a high level as to what this is?

A. Sure. To then also look at an individual's responses relative to other groups that may be similar in diagnosis.

Q. Okay. All right. But -- we will get to that, but, for now, on the Word Memory Test administered by
03:30:08 Dr. Denney in May 2021, Mr. Brockman's score qualified as a possible genuine memory impairment profile. Correct?

A. Yes.

Q. And I think you testified that Dr. Denney also administered the Nonverbal MSVT. Correct?

03:30:30 **A.** Yes.

Q. What is that?

A. The Nonverbal Medical Symptom Validity Test.

Q. And what is that test?

A. It's the same basic principle in terms of asking
03:30:46 someone to learn a series of drawings, some of which go

together or many of them go together. Again, it's a learning task but this time with nonverbal pictures, nonverbal information, rather than words.

Q. Okay. I am going to show you what is marked as DX-60. Are you able to see this?

A. Yes.

Q. Okay. And what is it?

A. It is the advanced interpretation printout for the Nonverbal Medical Symptom Validity Test.

Q. And for both the -- the MSVT and the nonverbal MSVT, can you just describe to the Court how is that administered? Like what does the patient do? I understand there are pictures or, you know -- but with respect to the computer, what happens?

A. So, the entire thing is computer-administered. The -- the stimuli are presented on a computer screen. An individual responds by either using a mouse or -- or a touch screen, and that is how most of the test is administered. There are a couple of subtests in which the examiner asks the questions, but the questions are generated on the computer, and you answer the questions right on the computer.

Q. And this scoring -- where is the scoring maintained?

A. The scoring happens within the computer -- the Green effort test platform.

Q. Okay. And -- and when it goes to -- Do you say there is an AI function? What is that?

A. Right. An advanced interpretation function.

Q. All right. You pay extra for that?

03:32:23 **A.** You do.

Q. And what does that do for you?

A. That will take the scores from the original test, and it will run it through the algorithms that you see here.

Q. All right. Is that a computerized process, the

03:32:37 transferring of those scores to the AI?

A. Yes. Yes.

Q. So, it's not as if you have any hand in that?

A. No.

Q. Or Dr. Denney had any hand in that --

03:32:43 **A.** No.

Q. -- at that point?

So, this scoring sheet looks a little different, but I see here it says, "Data could be valid, but apply Slick, et al. criterion." Is that the same as

03:32:59 a -- a possible genuine memory impairment profile, just collapsing those boxes we saw before?

A. Yes.

Q. Okay. That's DX-60. You -- you also testified that in May of 2021 Dr. Denney administered what's known as the

03:33:22 Victoria Symptom Validity Test. Correct?

A. Yes.

Q. Now, the Victoria Symptom Validity Test, does it have a built-in mechanism to try to identify dementia patients who -- who, you know, the test is being administered to?

03:33:40 **A.** No.

Q. Now, the Victoria Symptom Validity Test -- are there -- well, what are the risks with respect to administering this test to a potential dementia patient?

A. There is always a risk with any performance validity

03:34:03 test, including the Victoria Symptom Validity Test, that an individual with dementia will score below the cutoffs recommended by the test and identify the individual with dementia falsely, as either malingering or not putting forth adequate effort when, in fact, they may have.

03:34:23 **Q.** Okay. And what is -- like, how does the test work?

A. It's a digit recognition test. A person is shown a five-digit number for a certain number of seconds. The number goes away. And then -- so, it's also computer-administered. And then two-digit numbers -- or two five-

03:34:41 digit numbers are shown, the original number and the foil, and the person has to choose the number that they just saw.

Q. Okay. And is it broken down into easy and hard items?

03:34:53 **A.** Yes.

Q. Okay. And -- and does the test have a -- come with a manual?

A. Yes, it does.

Q. Okay. And what is included in the manual?

03:35:06 **A.** The manual includes scoring guidelines or interpretive guidelines, the psychometric properties of the test, some examples of individuals who have taken the test.

Q. All right. And when you enter this -- you do this

03:35:21 Victoria Symptom Validity Test, is it also computerized?

A. Yes.

Q. And are the results also spit out by a machine?

A. Yes.

Q. All right. In interpreting the Victoria Symptom

03:35:35 Validity Test, what was Dr. Denney's interpretation of Mr. Brockman's performance?

A. So, the -- the interpretive guidelines for the -- for the test is there are -- there are three different interpretations. There is -- depending upon the number of

03:35:54 errors that a person makes, there is a score that is simply acceptable. There is a score that's questionable, in which someone answers around chance. And then there is below chance. And the manual give s specific cutoffs, how many items do you need to get correct to be in the chance

03:36:15 range or below the chance range.

So, Dr. Denney focused on the difficult word pair tasks, in which Mr. Brockman got eight out of 24 correct, which, according to the manual, is in the chance range. Dr. Denney interpreted that as being below chance.

03:36:40 **Q.** So, in doing that, did Dr. Denney follow the manual?

A. No.

Q. So, he -- he changed the testing criteria from the manual put out by the Victoria Symptom Validity Test. Correct?

03:36:53 **A.** Correct.

Q. And what did he base his -- or use to justify moving the testing criteria to change the cutoff?

A. As I understand it, he said that the manual lists significantly below chance as a score that would happen by

03:37:14 chance 5 percent of the time or less.

When he included eight -- eight correct out of 24 as being significantly below chance, that actually was more like 8 eight percent rather than 5 percent chance.

03:37:34 So -- and from what I understand, he -- he claimed that he was justified in doing that because the symptom validity -- the Victoria Symptom Validity Test was published back in the '90s, and we now have a different understanding of what significantly below chance is. And,

03:37:53 so, therefore, he felt justified in essentially raising

the bar to call Mr. Brockman's score "chance" to then "below chance."

Q. Okay. And is that true, that there's now some agreement as to what represents "significantly below chance"?

03:38:14

A. In my opinion, no. There is no consensus within the field as to what constitutes "significantly below chance." There are individuals who have written articles who endorse various levels, 10 percent, 20 percent, but the

03:38:31

field has not come to a consensus about what "significantly below chance" should be.

Q. And what's the basis for your understanding of where the field stands on this?

A. Just this spring in the *Journal of the Clinical Neuropsychologist* there was a statement from a consensus

03:38:43

conference that was held by the American Academy of Clinical Neuropsychology that assembled a number of experts around the country -- I actually participated in that same conference in 2009 -- in which they made a

03:39:02

statement regarding the neuropsychological assessment of effort, response bias, and malingering. And in that document the -- there -- they don't say, "We have no consensus," but they never state a consensus about what "significantly below chance" means. They only use that

03:39:19

term and never quantify it in any objective manner.

Q. And having participated in that conference, what inference are you drawing from the absence of a definition?

A. That there was no consensus on what significantly below chance should actually mean mathematically.

Q. So, there is that part of it, but then you said there are articles that -- that talk about, you know, the different values.

By the way is this called the p-value when you are trying to calculate what significantly below chance means?

A. Yes.

Q. And what is the typical p-value used in social science papers?

A. .05.

Q. And what is the value used in the Victoria Symptom Validity Test?

A. According to the manual it's .05.

Q. Uh-huh. So it follows sort of the standard that is used in social science, correct?

A. Yes.

Q. And then -- but Dr. Denney used a different p-value?

A. Correct.

Q. And are you familiar with whether he based his moving the goal posts of the test on a particular article?

A. Yes. I believe so.

Q. And what article is that?

A. That is an article by Loring.

Q. Uh-huh.

03:40:18 **A.** And --

Q. And that article -- does that article have a statement specifically on the risk of moving the goal posts on dementia patients?

A. Yes.

03:40:31 **Q.** What does it say?

A. The authors conclude that individuals with dementia are more at risk for getting low scores or chance scores on the Victoria Symptom Validity Test, and as a result a chance score should be interpreted as a false positive

03:40:51 error.

In other words, so to indicate that in the chance level, performance is due to inadequate effort, the authors of the article say that -- that that interpretation should not be used because dementia

03:41:10 patients are at risk more than other patients with it -- of having their scores fall within that chance range.

THE COURT: Is the article in evidence?

MR. LOONAM: We have pointed to it before and used it. I don't know if it was entered into evidence, but

03:41:24 I am happy to enter it into evidence, Your Honor. I can

get a copy for Your Honor.

THE COURT: I would like to read the entire article.

MR. LOONAM: Sure. Yeah.

03:41:37 THE COURT: I didn't mean to interrupt. Maybe later. Maybe later.

MR. LOONAM: Sure. Sure. We will get Your Honor a copy of the article. I think we used it during our cross of Dr. Denney.

03:41:51 BY MR. LOONAM:

Q. And, you know, during his cross-examination, I believe, my memory is that Dr. Denney agreed that in administering validity tests, the cutoff needed to be adjusted for dementia patients? Do you agree with that

03:42:12 testimony?

A. Oh, yes.

Q. And I believe Dr. Denney agreed that the cutoffs to account for dementia patients, on the analyzing validity tests, would need to be made easier, or -- or --

03:42:27 **A.** Lower.

Q. -- or lower the cutoff?

A. Yes.

Q. Do you agree with that testimony?

A. Yes.

03:42:31 **Q.** Is that what Dr. Denney did in this Victoria Symptom

Validity Test?

A. No, he did not.

Q. What did he do?

A. He actually increased the score. If you just follow the manual, Mr. Brockman's score falls within the chance range. However, Dr. Denney sort of lowered -- he -- he made it -- he took a chance range score and made it below chance, which increased the likelihood of failure.

Q. To continue the sports metaphor that was started earlier today, is it fair to say he moved the goal posts?

A. Yes, I would say that.

Q. Okay. I am going to show you what is DX-65, and do you recognize DX-65?

A. Yes.

Q. And what is DX-65?

A. This looks like the Victoria Symptom Validity Test. This is a printout of the scores, of the summary scores of Mr. Brockman.

Q. And in the context of the Victoria Symptom Validity Test scoring system, what does "questionable" equal?

A. So that's the interpretation, that that's at chance.

Q. Chance?

A. Chance.

Q. Yeah. Yeah. So sometimes it's past, valid, chance, questionable, fail, invalid? Is that fair?

A. There are -- right. There are multiple terms that are used.

Q. Yeah. Each test has its on sort of vocabulary?

A. Yes.

03:44:01 **Q.** Okay. And, in addition, does the manual for this test guide the examiner in what the most objective and -- and reliable measure is of effort?

A. Yes.

Q. And what is that?

03:44:18 **A.** The total items correct is what the manual recommends to be used in the determination of the -- the interpretation of this test.

Q. And -- and did -- in reaching his analysis did Dr. Denney rely on the combined score, or did he rely on

03:44:39 singling out one score?

A. He did not rely on the total score, rather he relied just on the difficult items.

Q. And is that consistent with the manual for the Victoria Symptom Validity Test?

03:44:51 **A.** No, it is not.

MR. LOONAM: Can we go back to the screen?

BY MR. LOONAM:

Q. So, this is where we were on Dr. Denney's test, and as far as you have testified, Reliable Digit Span, valid;

03:45:19 Sentence Repetition test, valid; Denney Competency-Related

Test, valid; Green Word Memory Test, Genuine Memory Impairment Profile, Green Nonverbal Medical Symptom Validity Test, Genuine Memory Impairment Profile, and Victoria Symptom Validity Test was a chance performance, correct?

03:45:37

A. Yes.

Q. Who administers the next battery of neuropsychological tests?

A. I do.

03:45:55

Q. And in-between Dr. Denney's tests in May -- and when do you conduct your tests?

A. July.

Q. Okay. Is there any incident of significance with respect to Mr. Brockman's health?

03:46:06

A. Yes. He was admitted for urosepsis and delirium from late May to early June, or I guess really mid June, and then also underwent a general anesthesia for the UroLift.

Q. And the urosepsis hospitalization, were there any incidents that concerned Mr. Brockman's mental health?

03:46:34

A. I'm sorry. I don't quite understand the question.

Q. Well, in his July -- in his June hospitalization --

A. Yes.

Q. -- in addition to urosepsis, did -- did Mr. Brockman suffer from episode s of delirium?

03:46:51

A. Oh, yes. Yes.

Q. Okay. And what's the significance of that?
A. Well, there are a couple of things. One is that it reflects the fragility of his brain function, that an infection can result in his altered mental status, and
03:47:07 confusion and -- and also that given his -- that delirium can result in a permanent decline in cognitive function or brain function, even when it resolves mostly, for some patients delirium doesn't go away completely and patients are left with a lower baseline than when they started.
03:47:32 **Q.** Okay. And so in the July tests -- describe your examination in July. What were your interactions with Mr. Brockman and your observations?
A. Well, I interviewed him. I administered a number of different neuropsychological tests as well as performance
03:47:55 validity tests. And you asked what my impression was?
Q. Yes. What was your impression during the interview portion of Mr. Brockman?
A. I was struck by how easily confused he was, how off track he was at times. He would certainly have moments
03:48:12 when he was -- when he seemed to understand what I was there for and could respond appropriately, but at other times he would say things that were really unrelated to my questions.

He thought at various times that I was a
03:48:27 consultant for Reynolds and Reynolds, that I was helping

with a computer program. Sometimes I simply couldn't follow his -- his train of thought.

He had difficulty following some instructions on test measures. His endurance was significantly decreased. I couldn't get through nearly what I -- what Dr. Denney was able to do in one day in May versus what I tried to do in two days in July. So there were a number of cognitive issues.

Q. And had you watched the videotaped interview of the interview conducted largely by Dr. Agronin, but together with Dr. Denney, back in May? Or Dr. Dietz. I'm sorry, I misspoke. I'm sorry. Strike it, let me rephrase.

Did you watch the videotape of the -- the interview conducted largely by Dr. Dietz but also with Dr. Denney back in May?

A. Yes, I did.

Q. Okay. And can you compare your -- what you observed when you examined Mr. Brockman in person in July, versus what you observed in the videotape in May?

A. Yes. From May to July I found that his -- his mental status had really changed significantly. He was not nearly as attentive. He was more easily confused. He was less able to stay on track. His mental endurance was decreased, his mental processing speed was decreased. He looked much worse with regard to his mental status.

Q. Okay. And that's -- and what do you attribute that to?

A. I attribute that to the progression of his dementia, and especially the effects from his delirium in late May and June.

Q. Okay.

A. And also -- and the possibility of some effect possibly of his general anesthesia for his UroLift in later June.

Q. So the anesthesia combined with the delirium episodes and the progression?

A. Yes.

Q. Okay. Did you administer performance validity tests in connection with your examination of Mr. Brockman?

A. Yes, I did.

Q. Which tests did you administer?

A. I administered the Medical Symptom Validity Test, the Test of Memory Malingering, the A-Test, the Rey 15-Item Test with Recognition, the Coin-in-the-Hand Test, Reliable Digit Span. I think that is all of them.

Q. The RBANS?

A. The -- the RBANS was a test -- a general neuropsychological test for which they had embedded validity measures in it, so they were not stand-alone.

Q. So, the RBANS Effort Index and the RBANS Effort

Scale?

A. Yes.

Q. Okay. And when you said -- can you describe for the Court the difference between the Stand-Alone Validity Test and an Embedded Validity Test?

03:51:42

A. Sure. So, a Stand-Alone Validity Test is a test that is -- for which the only purpose is to assess for effort and validity. And Embedded Validity Test is a test that has been -- or a score perhaps, or a combination of

03:52:01

scores, that have been derived from a regular clinical neuropsychological test, something that you would give a patient to assess some aspect of their functioning from which you can draw out indicators that are sensitive to inadequate effort and validity.

03:52:20

So those tests do what is called sort of double duty. They can both provide important clinical information, as well as provide information about validity and effort.

Q. Okay. I think one of the tests you mentioned was

03:52:31

the -- is it the TOMM, the Test of Memory Malingering?

A. Yes.

Q. And so what is that test?

A. That is another forced choice test, where an individual is shown a series of pictures, asked to

03:52:44

remember them, and then they're later shown two choices

from which they are asked to then pick the picture that they had seen before.

Q. And how did Mr. Brockman do on the TOMM?

A. Mr. Brockman obtained a valid range score on the TOMM.

03:53:00

Q. Okay. And in his report, did Dr. Denney criticize your administration of this test?

A. He did.

Q. Okay. And why -- what did Dr. Denney take issue with?

03:53:10

A. Dr. Denney said that I should have administered -- there is -- there are two learning trials, and then there is a Delayed Recall Trial. Dr. Denney thought that I should have also administered the Delayed Recall Trial, or a retention trial.

03:53:24

Q. And, well, what's your response to Dr. Denney?

A. I disagree with that. It a purely optional trial. The clinicians that I know tend to not administer the retention trial because the trial already takes a long time to administer, and there is a number of studies that have looked at the TOMM that don't even look at the retention trial.

03:53:46

So I don't see it at all as being critical in the assessment of malingering with the use of the TOMM.

Q. And can you explain for the Court the interplay

03:53:59

between the time you have -- the time management, especially with respect to the elderly in administering these tests?

A. Yes. So always with -- with older adults, endurance can be a problem. They tend to work more slowly than younger adults. They have less endurance. They fatigue more quickly.

So you are always trying to maximize your evaluation by sort of front loading it with the most important things. In any sort of shopping list of neuropsychological tests, there are those that you really want to give, those that you would like to give, and those that if you have time you'll give for more and more information.

So in Dr. -- in Mr. Brockman's case, in July his endurance was such, his attention was such, that I felt I had a limited amount of time to be able to really get an optimal performance from him because his endurance and his ability to persist were -- were so low.

Q. All right. You had mentioned the Coin-in-the-Hand Test?

A. Yes.

Q. Okay. What is that?

A. That is simply you put a coin in your hand. The examinee sees which hand it's in. You then close both

palms. You ask the person to close their eyes, count backwards from ten and then when they open their eyes to identify which coin the hand -- which hand the coin was in.

03:55:30 **Q.** And how did Mr. Brockman perform on the Coin-in-the-Hand Test?

A. Mr. Brockman obtained a valid range score.

Q. Okay. The A-Test, what is that?

A. The A-Test is -- occurs when you read a series of

03:55:51 letters at the rate of one every other second, and the examinee is to signal, tap on the table, for example, every time the letter "A" is said.

Q. And how did Mr. Brockman perform?

A. So Mr. Brockman made more errors -- he made more

03:56:08 errors. His error rate was above the cutoff for validity, but while giving the test, he seemed to be sort of out of it. He seemed to be staring off into space. He didn't seem to be paying attention.

So what I typically do in those cases is

03:56:27 when I finish the test, I then ask the patient -- first of all, What was it that I asked you to do, to make sure that they had remembered the instructions. Because if you fail the A-Test because you don't remember the instructions that has nothing to do with effort, that has to do with

03:56:40 their mental status.

So when I asked Mr. Brockman that question, and his comments are in my report, he -- he produced some unusual comments like I couldn't quite follow what he was thinking, but he seemed to be quite confused. When I asked him what I had asked him to do, he couldn't tell me.

03:56:56

I said, 'Well, I read a series of letters. What did you want me to do with them -- what did you think I wanted you to do?' He said, 'Remember them.' Which was completely wrong.

03:57:07

So my -- my thought about his performance on that task was -- was that he did not perform well because he was simply -- he became too confused in the middle of it.

03:57:21

So I tried to reorient him, remind him why I was there, who I was, what the evaluation was all about. I gave him the instructions. I asked him to repeat the instructions. I think I did that a couple of times until finally I felt that he was sort of back on track and then I readministered the test.

03:57:39

Q. So is the A-Test one of those tests like the Green tests that accounts for dementia patients and has a genuine memory impairment profile?

A. No, it does not.

Q. And so in your clinical judgment, you -- you observed

03:57:49

that -- that the defendant was confused and did not understand the task at hand?

A. I felt that the -- that he initially understood the task at hand. But then as the tasks persisted, he did not. He lost track of what he was supposed to do.

Q. Okay. And then you readministered the test -- tell us, how many times do you have to instruct him on -- to make sure he understood this -- the task at hand?

A. I think at least a couple of times.

Q. And is that something you have done in your clinical practice to try and see if you can get in administering these tests to patients with short-term memory problems?

A. Yes. Or -- when I see patients, and -- and they are responding to any test in a way that doesn't make sense, that just seems random, or just they're responding in a way that makes me think that they don't know what their -- it is that they are supposed to do, that they -- that they seem to understand the instructions when I started, but then midway through the test they start responding in ways that just don't make much sense, then I will -- typically I will either stop the test, or let the test go through to completion, and then we will ask them, 'What did you remember I asked you to do?' And then if they don't know that, then I will -- I will give them the directions again and re-administer the test.

Q. And -- and I don't know if it was respect to this test, or another test, but during his testimony Dr. Denney accused you of coaching the defendant on these tests.

Did -- are you familiar -- are you aware of that?

A. Yes.

Q. Okay. And what is your response to Dr. Denney's accusation that on these tests, that you coached the -- the defendant?

A. I never coached the defendant. I readministered the instructions, but I -- I simply gave the instructions again as they are to be given. I didn't tell him how he should do on the test. I didn't coach him on how to succeed on the test. I only gave him the directions again.

Q. You readministered the test and did you disclose the procedures you used in your report that was disclosed to Dr. Denney?

A. Yes.

Q. And after you reoriented the defendant and instructed him several times on the test, what -- what score did the defendant receive?

A. He obtained a valid range score.

Q. Okay. And what's the RBANS Effort Index?

A. So that is a -- the RBANS is the Repeatable Battery

Assessment of Neuropsychological Status, and there are two built-in embedded validity indicators and Mr. Brockman obtained valid range scores on both of those.

Q. Okay. On effort on the index and on the scale?

04:00:53 **A.** Yes.

Q. And then the Medical Symptom Validity Test you have already discussed, correct?

A. Yes.

Q. And I am going to put up DX-61.

04:01:06 MR. LOONAM: Can we go back? I'm sorry. Thank you, sir.

BY MR. LOONAM:

Q. And do you recognize DX-61?

A. Yes.

04:01:20 **Q.** What do you recognize it to be?

A. Sorry?

Q. What do you recognize it to be?

A. Oh, this is the advanced interpretation printout of the Medical Symptom Validity Test that was administered to

04:01:30 Mr. Brockman in July.

Q. Okay. And what does it reflect with respect to the algorithm part, the math part of the flow chart?

A. Right. It, again, reflects that Mr. Brockman produced a possible genuine memory impairment profile.

04:01:52 **Q.** Okay. And then you testified that you also -- let

me make sure I am here. You also administered the Reliable Digit Span?

A. Yes.

Q. Okay. And how did the defendant do?

04:02:12 **A.** Mr. Brockman obtained a valid range score on the Reliable Digit Span.

Q. Okay. And did you administer the Rey 15-Item Test With Recognition during your July exam?

A. Yes, I did.

04:02:37 **Q.** And how did Mr. Brockman do?

A. Well, as we have discussed previously, the original cutoff scores for the Rey 15-Item Test With Recognition are far too high for people over the age of 60 and especially those with dementia. And so there have been

04:02:59 suggestions for alternate scoring and alternate cutoff scores for that.

So using the alternate cutoff scores for individuals with -- for older individuals and individuals with dementia, Mr. Brockman obtained valid range scores.

04:03:18 THE COURT: May I ask a quick question?

MR. LOONAM: Of course.

THE WITNESS: Yes.

THE COURT: Doctor, is there a consensus that this accommodation for scores should be done, or is that on

04:03:30 a practitioner by practitioner -- on a practitioner -- on a

practitioner-by-practitioner basis, or is there some consensus that needs to be adjusted?

THE WITNESS: Yes, so there -- there is a consensus that -- that individuals with dementia, individuals with very severe traumatic brain injury with a long period of unconsciousness, individuals with very severe mental disorders like schizophrenia, that they will -- that as a group, those folks, patients in those groups will score lower on performance validity tests and will -- and will not pass as many performance validity tests. And so scores have to be adjusted to accommodate those groups.

BY MR. LOONAM:

Q. And that's widely recognized, correct?

A. Yes.

Q. In the literature, that to account for dementia patients, you need to adjust the cutoff scores to account for a dementia patient?

All right. And did you also administer the Conners CPT 3 validity test?

A. So the -- the -- the Conners CPT 3 is not a validity test.

Q. Okay.

A. It's a Continuous Performance Test that measures sustained attention.

Q. I see. I see. And how was Mr. Brockman's sustained attention?

A. It fell well below normal. And, however, the CPT 3 does generate a validity comment that -- that because the 04:04:59 number of errors that Mr. Brockman made raised a concern, either that the person didn't understand the directions, was severely impaired, or was not putting forth adequate effort.

MR. LOONAM: Okay. All right. Can we bring up 04:05:17 the other screen, and see -- I think, so -- and I think this is -- let's see here.

BY MR. LOONAM:

Q. So this covers the validity tests, but does not include the Conners embedded -- it sounds like it's an 04:05:36 embedded function?

A. It is not even really an embedded function per se.

Q. So it's not a validity test; is that fair?

A. It is not. But the computer program will alert the examiner if there are more errors than typically 04:05:52 encountered.

Q. Okay. And so what -- what was the next evaluation of the defendant after your July exam?

A. I believe it was my October 2nd exam.

Q. Okay. And what validity tests did you administer in 04:06:11 the October 2nd exam?

A. The medical symptom validity test, Reliable Digit Span, Coin-in-the-Hand Test, Rey 15-Item Test With Recognition.

Q. And did you also administer the A-test again or --

04:06:32 **A.** I don't recall offhand.

Q. Yeah. No. Fair enough. It would be in your report. Let me make sure I am not leading you astray.

A. I think I did.

Q. Yeah. The Rey-15 test. How did Mr. Brockman score

04:06:59 on the Rey-15 test during your administration in October?

A. Again, he produced valid range scores.

Q. And you administered that with the recognition piece?

A. Yes.

Q. Does Dr. Denney take issue with your scoring on the

04:07:16 Rey-15 test that you are aware of?

A. Yes. And he cites the same article that I did. Dr. Denney indicates that there are two -- without getting too deep into the weeds, there are -- the article by Fazio, who arguably has published the biggest paper on the

04:07:39 Rey 15-Item Test with an older population and with a demented population.

So, Fazio suggested a new combination score and then does not, however, list a cutoff, simply says, if -- if you plug these variables into this score,

04:07:59 then a score less than two is uncommon. That -- that's

all Fazio says. He does not say that it makes it invalid. Indicating, however, the percent of individuals who score less than two, or one and zero.

And then, however, Fazio and colleagues say but even a better way of looking at the performance on the Rey 15-Item Test With Recognition is by doing a pattern analysis, and they list three separate scores that an individual can generate from the Rey 15-Item Test. And they say, if you fail three of these, three of these, then this is what they describe as a pathognomonic marker, or sign, of a likely disingenuous profile, because no one in our sample gets all of these three wrong. Zero percent does.

So, I calculated both the pattern analysis profile as well as the new combination score, and on both of those -- well, on the most important one, arguably, the pattern analysis score, Mr. Brockman's performance fell within the valid range.

Q. Okay. And you are not going to make me say that, the term patho --

A. Pathognomonic.

Q. -- pathognomonic. So, when you looked at the sort of -- the combination of the three sets, Mr. Brockman obtained a valid score; is that accurate?

A. Yes.

Q. Okay. On the A-Test how did he do?

A. He produced a valid range score. I believe he made two errors, and the cutoff is more than two errors.

Q. Reliable Digit Span?

04:09:40 **A.** A valid range score.

Q. And then the -- the Green Medical Symptom Validity Test?

A. Right. He produced a possible genuine memory impairment profile.

04:09:58 MR. LOONAM: All right. Can we switch over?

BY MR. LOONAM:

Q. All right. Again, reflected here --

A. Yes.

Q. -- in Defense Exhibit 62.

04:10:23 And then on the -- did you also administer the Coin-in-the-Hand Test in October?

A. Yes, I did.

Q. Okay. And how did Mr. Brockman do?

A. So, the -- the general cutoff recommended is seven 04:10:41 correct or fewer, and Mr. Brockman obtained a score of seven, which is, technically, an invalid score, although, again, if you look at the literature on the Coin-in-the-Hand Test, for a moderate to severe dementia group, at least one study found that five out of 20 people 04:11:01 failed it. And, in fact, if you look at the range of

scores on the Coin-in-the-Hand Test, some dementia patients got as few as five correct. So, Mr. Brockman had seven correct.

So, while it's technically an invalid range score, I -- arguably, again, modifying that score for someone in his age group and someone with his diagnosis, you could also call that a valid range score.

Q. Yeah.

A. I would also add that the interesting thing that -- the qualitative observation of Mr. Brockman was that, when you put the coin in the hand and then you close both hands like this (indicating) to make a fist, Mr. Brockman is watching me do this, and when I make the fist he does this (indicating). He does the same thing.

He's basically -- he is mimicking my behavior, which is a very unusual thing to see. There's a name for it. It's called "echopraxia." And it can reflect damage to some frontal lobe structures, because he's -- it's like he is -- he sees what I am doing and -- and he suddenly mimics that behavior. And that's something that you see with patients with brain damage.

Q. Okay. And that's -- can you spell that for the court reporter?

A. E-C-H-O-P-R-A-X-I-S [sic].

Q. And then -- so, it's accurately reflected here up on

the screen. You know, the Rey-15, A-Test, Reliable Digit Span were valid; the Green Medical Symptom Validity Test, Genuine Memory Impairment Profile, and the coin in the test [sic] is the seven out of the ten that you just described. Correct?

A. Yes.

Q. And then the next battery of neuropsychological testing was administered by?

A. Dr. Denney.

Q. Also in October?

A. Yes.

Q. Okay. And do you recall what performance validity tests Dr. Denney administered?

A. The Medical Symptom Validity Test, the Nonverbal Medical Symptom Validity Test, um...

Q. How about --

MR. LOONAM: Is it fair if I refresh the witness's recollection?

MR. SMITH: Sure.

MR. LOONAM: Any objection?

MR. SMITH: No.

THE COURT: Of course.

A. Reliable Digit Span, again, and Rey-15 test with recognition.

BY MR. LOONAM:

Q. Okay. And with respect to the Reliable Digit Span test, how did Mr. Brockman score?

A. Valid range score.

Q. Okay. With respect to the Rey 15-Item Test, is this an area where you and Dr. Denney agree or disagree?

04:13:35

A. Disagree.

Q. Okay. And describe that disagreement.

A. Well, Dr. Denney never -- Dr. Denney seems to suggest that -- that Fazio, et al, actually established a cutoff of invalidity for the Rey 15-Item Test, which my reading of the article, that's not the case.

04:13:57

Mr. Brockman -- sorry -- Dr. Denney also never mentions the -- the pattern analysis or the profile analysis, again, that the authors call the pathognomonic sign of a likely disingenuous performance, and the authors say it's better than the combination score.

04:14:15

So, however, when I plug in the values from the Rey 15-Item Test that Dr. Denney administered, Mr. Brockman's performance, again, falls well within the valid range.

04:14:33

Q. And when you say -- so, Dr. Denney -- he focuses on the one item, but he doesn't even mention sort of what the authors of the article say is the -- the better measure of validity?

A. Not that I have seen.

04:14:46

Q. And then I am going to show you --

MR. LOONAM: Can we switch over to the ELMO? I'm sorry. I am keeping you on your toes there.

BY MR. LOONAM:

04:14:56 **Q.** What is this that we're looking at here?

A. That is the recognition portion of the Rey 15-Item Test.

Q. Okay. And what are we looking at here?

A. That is the free recall portion of the recognition --

04:15:08 of the Rey 15-Item Test.

Q. And do you and Dr. Denney score this portion of the test differently?

A. Yes, we do.

Q. Okay. And why is that?

04:15:17 **A.** Well, because intrusion errors -- intrusions are things that a patient draws that were not on the original 15 stimuli. And, so, it appears here that, after Mr. Brockman sees the 15 stimulator taken away and then he is asked to draw it just from memory, he draws initially

04:15:39 what appears to be the face of a clock, a partial circle and then with, it looks like, a couple of numbers. But then he crosses it out. He draws another partial circle and then a better formed circle underneath.

A circle is on the original 15-item

04:15:54 display. So, it's -- the clock -- if he left the clock

alone and said, 'Yeah, I think this was on there,' then that would be an intrusion error. But the way I look at this, he -- he crosses the clock out and then draws a circle. The circle is among the 15 items. So, there is no intrusion error there from my perspective.

Q. So, in other words, he recognized -- he demonstrated recognition that the clock wasn't among the first 15 items?

A. That's the way it appears to me, yes.

MR. LOONAM: Okay. Can we switch back? It helps me keep track of where we are here.

BY MR. LOONAM:

Q. So, you scored the Rey 15-Item Test as valid. And that's -- the difference of opinion is both over Fazio and the scoring in this instance. Correct?

A. Right. Right. I scored "valid" because the pattern analysis is -- is clearly within -- within -- within the acceptable limits that the authors describe. And I also would not score what you just saw as an intrusion error.

Q. Yeah. And the pattern analysis, again, how did the authors describe that? As the preferred method or the superior method?

A. Right. So -- so, what the authors say is that there are -- are three scores that, if combined together, if they are present, then, no one in their sample, no

dementia patients, get all of those three items correct. So zero percent. So, that's why they call it such a -- such a critical sign of disingenuous performance, because if you're testing a dementia patient and literally not one dementia patient that they studied ever got that score, that would certainly raise a question about the validity of the 15-item test.

Q. Okay. Then we have Dr. Denney's administration, again, of the Green MSVT. Does Mr. Brockman obtain a possible Genuine Memory Impairment Profile on the administration of that test?

A. Yes, he does.

Q. And on Dr. Green's Medical Symptom Validity Test, does the defendant obtain a possible Genuine Memory Impairment Profile on the administration of that test by Dr. Denney?

A. Yes, he does.

Q. And so is --

MR. LOONAM: And we can -- can we switch back?

BY MR. LOONAM:

Q. I just want to -- There was some question about this during Dr. Denney's testimony, so let's make sure we dot our I's and cross our T's here.

What is this?

A. This is the Nonverbal Medical Symptom Validity Test

administered by Dr. Denney.

Q. Okay. And -- and -- and what does it reflect?

A. It reflects the genuine memory -- a possible Genuine Memory Impairment Profile.

04:18:58 **Q.** Okay. And that was DX-63.

I am going to put up DX-64 now. And what does this reflect?

A. This is the Medical Symptom Validity Test, the advanced interpretation profile from the test administered

04:19:25 by Dr. Denney on October 26th.

Q. Okay. And, so, how many -- how many -- over the different, you know, battery of tests, how many Green stand-alone validity tests have been administered to the defendant?

04:19:43 **A.** Six.

Q. Okay. And what have been the results of every single one of those tests?

A. They have all produced a possible genuine impairment memory profile.

04:19:54 **Q.** And can you remind the Court of the research that was conducted by Dr. Denney's paper regarding the administration of multiple Green tests and what the significance was as to the sensitivity of detecting the fakers?

04:20:11 **A.** Yes. So, Dr. Denney's article revealed that among

his simulators, people faking dementia, all graduate students in psychology, that not one of the 50 was able to produce a Genuine Memory Impairment Profile across all three of the Green tests. And so, therefore, it was
04:20:34 sensitive to -- when given all three, it was sensitive to simulation rather than producing a profile that suggested a possible genuine memory impairment.

Q. In other words, at least in that study, it found the fakers 100 percent of the time when three tests were
04:20:57 administered?

A. Yes.

Q. Okay. And so let's now go to the -- the next boxes here. Okay? Let's understand these. Okay? You know, this is where the clinical judgment kicks in and this is
04:21:18 where you and Dr. Denney disagree on the interpretation of the Green tests. Correct?

A. Yes.

Q. And Dr. Denney, if you recall, talks about comparison groups and how Mr. Brockman falls below. His scores are,
04:21:38 you know, way below the dementia profile group or other comparison dementia groups. Do you recall that?

A. Yes.

Q. Okay. I am going to -- we are just going to go through an example of this, but this is Dr. Denney's
04:21:56 supplemental report.

MR. LANGSTON: Is it 2? Government 2?

MR. SMITH: Government 2, yes.

MR. LANGSTON: Yeah. So Government 2. Sorry. My item is not marked here.

04:22:04 I'm just going to put this up for the Court to look at. And this is Page 11 of Government 2.

BY MR. LOONAM:

Q. What are we looking at here?

A. So, this is a graph of the different subtests of the

04:22:22 Nonverbal Medical Symptom Validity Test, and you see Mr. Brockman's scores on each of the subtests. And then the other dotted lines, sort of, that you see reflects the average scores of the -- of the comparison groups that are listed underneath the profile.

04:22:41 **Q.** Okay. So, this is important here.

What -- what's the -- what's the issue with this chart if you're comparing the performance of an individual against the -- When you say the average, is that the mean?

04:22:56 **A.** Yes. Yes.

Q. When you compare the performance of an individual against the performance -- the mean of a group's performance, what's the risk?

A. Oh. Well, the risk is that the mean is simply one

04:23:09 number. It's a measure of the average, the central

tendency of the scores. It does not take into account the fluctuation or the deviation of scores within the sample or within the group.

Q. And, so, you know, if you have a group of three, one person scores 100, one person scores a zero, one person scores 50, you know, an average line is going to show a 50 right?

A. Yes.

Q. So, somebody who scored a 20 was way below that average?

A. Yes.

Q. And so what -- so, what other data is critically important to being able to understand these charts?

A. Knowing the standard deviation of each of those scores and also even -- and equally important would be knowing the range of the scores; that is, because the standard deviation tells you the dispersion or the distribution of scores, how much scores vary from the mean.

Q. Uh-huh.

A. But that doesn't always capture the range. So, the range really tells you the lowest score obtained by a sample and the highest score obtained by a sample.

Q. In other words, the range -- if you have a group of genuine dementia patients, the range will tell you, hey, a

genuine dementia patient scored at this point and then all the way through up to this point.

A. Yes.

Q. Is that accurate?

04:24:45 **A.** Yes. That's the range.

Q. And -- okay. And this chart doesn't show that. Correct?

A. Correct.

Q. This chart just shows tracking an individual

04:24:52 performance against the mean of different groups. Correct?

A. Yes.

Q. Now, let's talk about the groups. How are these groups selected?

04:25:05 **A.** Well, they can be selected by the program or they can be selected by the examiner.

Q. And are you familiar with Dr. Denney's testimony that in this instance he selected the comparison groups himself?

04:25:15 **A.** Actually, no, I was not aware of that.

Q. Okay. Well, let's see what we know about some of these groups.

Oh, by the way, when you're doing a comparison, in addition to knowing the standard deviation

04:25:30 and the range, what other sort of information is important

to know about the cohort that you're comparing on the individual performance?

A. Oh, well, things like age would be important. Like if you have information about how the diagnoses were made on these patient groups. So, those would be some important characteristics to know.

Q. Okay. I am going to -- and the data that's in here that comes out from the machine, do you know how that data, you know, comes into -- is this spit out by Dr. Green's computer program that he sells to clinicians? Is that accurate?

A. Yes.

Q. And how does that data, like, get to Dr. Green?

A. Some -- some data comes from published articles and studies, and some data -- some comes from -- as I understand it, the way it seems to me, as I read his manual, is that this is data that is generated by other people, by clinicians, and they sort of -- and they send it in to him with the scores of how their group of patients or their simulators performed on these measures.

Q. And no indication of whether that data is verified in any way?

A. The data that -- No. Right. The data that comes from a public study, you can examine that --

Q. Uh-huh.

A. -- in more detail. But the data that just comes from someone who uses these tests and has gathered data in some way and sends it in to Dr. Green, there is no way of really knowing what the source is of that and -- and other information about it.

Q. Okay. I am -- for example, 33 MMC clinical dementia cases. What do we know about that group?

A. I don't know anything about that group. I don't know.

Q. Nothing. And, so, Dr. Denney claims he has data, puts it in there and just -- and doesn't reveal a standard deviation range or information about the cohort as a comparison group? Is that what we have to go on as far as 33 MMC clinical dementia cases?

A. Essentially, yes.

Q. Okay.

THE COURT: Just -- may I ask a question?

But you don't know whether he took it from the program? If he took it from the program, would you be able to figure out what that group was?

THE WITNESS: Oh. So, that was not taken from -- from the program.

THE COURT: It wasn't?

THE WITNESS: No.

THE COURT: Okay.

BY MR. LOONAM:

Q. That wasn't. And, similarly, are you aware of -- You know, 48 sophisticated dementia simulators, you know, Armstead-Jehle and Denney. Do you know if that's taken from the program, or if Dr. Denney put in his own data there for the sophisticated dementia simulators?

A. I don't know.

Q. Okay. And is that the -- is that the group that we are referring to of -- of graduate students? Do you know?

A. Oh, I don't know. I would need to see the article again.

Q. Okay. All right.

THE COURT: Okay. Counsel, we are going to take a brief recess, just for the afternoon, because it's almost 5:00, and I need to get things organized since we are going to be working a little late tonight.

MR. LANGSTON: Yes, sir.

THE COURT: So, if we can take just maybe about a ten-minute break and we will get started again.

MR. LOONAM: Yes, sir. Thank you.

And, Your Honor, before we break, is there any objection if we waive Mr. Brockman's appearance for the balance of the day?

THE COURT: Not a problem. I expect this, to try to work a little late to see if we can get as far as we

can.

MR. LOONAM: Yes, sir. And we are grateful for that.

THE COURT: Not a problem.

04:29:29 THE CASE MANAGER: All rise.

(Proceedings recessed from 4:29 p.m. to 4:54 p.m.)

THE CASE MANAGER: All rise.

THE COURT: Please be seated, everyone.

You may continue.

04:54:06 MR. LOONAM: Thank you, sir.

BY MR. LOONAM:

Q. All right. We were talking about the problems of comparing --

THE COURT: One second. I'm sorry.

04:54:23 MR. LOONAM: Yes, sir.

THE COURT: I'm sorry.

BY MR. LOONAM:

Q. We were talking about the problems with comparing an individual performance versus the mean of a group and how 04:54:33 that can -- can be potentially misleading. Correct?

A. Yes.

Q. And so -- and how you and Dr. Denney differ in your subjective clinical judgment in determining whether Bob has a genuine memory impairment, because he qualified for 04:55:00 the possible Genuine Memory Impairment Profile. Correct?

A. Yes.

Q. And one of the things that the Green test says to look at are the comparison groups. Correct?

A. Yes.

04:55:15 **Q.** And you have explained that when you look at the comparison groups, understanding the standard deviation and the brain is critical. Correct?

A. Yes.

Q. And in conducting your analysis of the comparison

04:55:25 groups, did you consider the range and standard deviations for dementia profile groups?

A. Yes.

Q. And what did you find in your analysis?

A. Well, that -- when you look at the standard

04:55:39 deviations of the groups for which you can find the standard deviations, is that in the majority of cases Mr. Brockman's score falls within two standard deviations of the mean of the comparison groups.

Q. And what about did you find -- in exercising your

04:56:01 clinical judgment, did you look at other dementia patient groups and compare them to Bob's scores?

A. Yes.

Q. And what did you find?

A. Well, I found a similar finding and, also, I -- I --

04:56:17 there was some data that actually had the range of scores,

so you could see in any group what's the lowest score and what's the highest score. And, so, in those cases, this -- that gives you a more specific look at in this --

First of all, what -- what the range tells you is that dementia patients produce a wide range of scores. For any given subtest among these Green tests, some dementia patients -- and, remember, so each of these scores counts as a percent, correct.

Q. Uh-huh.

A. And, so, some dementia patients are getting, depending upon the subtests, 30 percent correct and some dementia patients are getting 80 percent correct. So, there's -- there's significant variability among dementia patients.

But -- so -- but, in my analysis, what I found was that in the Green subtest, either the -- the comparison groups produced -- when you look at the standard deviation, Mr. Brockman's scores fell either within two standard deviations of the mean or were equal to or higher than the lowest score obtained by one of these groups.

Q. So, in other words, Mr. Brockman's scores were consistent with other known dementia patients who had taken this test; is that accurate?

A. Yes. Or I guess what I would -- consistent with --

what I would say is that his -- his scores did not fall significantly below these other groups.

Q. Yeah. In no statistically significant way. Correct?

A. Right.

04:58:10 **Q.** Okay. Now, in addition to the comparison groups, what other information do you use in exercising your clinical judgment to determine whether Bob qualifies -- you know, once he mathematically qualified for a possible Genuine Memory Impairment Profile, but what other

04:58:39 information do you use to assess whether or not he's malingering?

A. Well, then, I -- I would use the other information available to me, which would include the test results themselves, my observations of Mr. Brockman, the

04:58:58 neuroimaging, the neurodiagnostic studies, just sort of the history of his illness, the collateral information as well that came from other sources, also look at the evaluations conducted by Dr. Agronin, Dr. Wisniewski, Dr. Whitlow. So, I am trying to look at the -- at the big

04:59:28 picture and combine that information together to arrive at a conclusion.

Q. Okay. So let's -- so, yeah, so lots of different pieces of information, you are sort of putting it all together like a mosaic, so it makes sense, is that

04:59:41 accurate?

A. Yes.
Q. So, let's talk about the collateral sources. Did you conduct your own collateral interviews of sources in this case?
04:59:49 **A.** Yes, I did.
Q. Okay. And we will run through who they are, but since conducting those collateral interviews, have you learned anything that would cause you to question the reliability of one or more of the collateral interviews
05:00:06 you conducted?
A. Yes.
Q. Okay. So let's start with -- just give us a list of who you self interviewed?
A. I interviewed Mrs. Brockman twice. I interviewed
05:00:17 Reverend Jackson. I interviewed Donna Ball, who is Mr. Brockman's personal secretary. I interviewed Robin Gilliland, who was a legal assistant at Reynolds and Reynolds. And I also interviewed his bookkeeper, whose name escapes me now.
05:00:40 **Q.** Okay.
A. Sorry. It's in my report.
Q. Okay. And overall what's the -- the picture painted of Mr. Brockman's current cognitive impairment through those collateral interviews?
05:00:54 **A.** Well, the collateral interviews as a general rule

described a decline in Mr. Brockman's functioning beginning back 2017 or so, perhaps, that has continued and progressed over that time.

Q. Okay. And with respect to the collateral interviews you conducted yourself, which, if any, do you have reason to question the reliability of?

A. The collateral interview of Reverend Jackson.

Q. Okay. And why is that?

A. I understand that he was less than forthcoming with some IRS agents and so makes me wonder if he was controlling the information that he was giving them, he may have been controlling the information that he also gave to me.

Q. Okay. And so what does that cause you to do with respect to the information provided to you by Reverend Jackson?

A. I -- I simply can't put much stock in it.

Q. Okay. And did you consider collateral interviews conducted by others in this case?

A. Yes.

Q. Okay. And who?

A. Dr. Agronin interviewed Dr. Slade, interviewed Frank Gutierrez and also Tommy Barras.

Q. Okay. And of those interviews, is there -- is there any interview that you question the reliability of?

A. Yes.

Q. Which one?

A. Tommy Barras.

Q. Why?

05:02:26 **A.** Dr. Agronin's report indicates that Tommy Barras described a decline in Mr. Brockman's functioning before he left Reynolds and Reynolds. He was having difficulty with certain decisions and other information and yet -- yet his -- he testified during this hearing and during his 05:02:53 testimony here he indicated that he saw no evidence of any kind of decline and that Mr. Brockman was perfectly intact up until the day he left Reynolds and Reynolds.

Q. What do you make of that?

A. Well, it's -- it's in contradiction to the report 05:03:11 that Dr. Agronin describes. I don't know where the truth is in any of that, so I just have to discount that.

Q. Okay. And the balance of the collateral interviews, do they assist in exercising your clinical judgment?

A. Yes.

05:03:29 **Q.** Okay. In what way?

A. Well, they provide others' observations of Mr. Brockman's functioning over time, and evidence of cognitive issues while he was still at Reynolds and Reynolds as well as the progression of his decline over 05:03:50 time.

Q. And did you observe the testimony of Frank Gutierrez earlier today?

A. Yes, I did.

Q. And does -- did Frank -- Mr. Gutierrez's testimony support your conclusion?

A. Yes.

Q. Tell us how.

A. Well, Mr. Gutierrez, who spends 12 hours a day with Mr. Brockman, described the kind of assistance that he needed, the confusion that he exhibited. I had not really even a conversation with Mr. Gutierrez when I saw him in October, but during the course of my interview with Mr. Brockman, Mr. Brockman indicated that two of Mr. Gutierrez's sons also provide care for him.

So during a break I -- when I went out to get Mr. Gutierrez to help Mr. Brockman get to the bathroom, just on the way back to the conference room I mentioned to Mr. Gutierrez, 'So your two sons also work with Mr. Brockman?' And Mr. Gutierrez says, 'No, they don't. For some reason he thinks they do, and I have corrected him but he doesn't seem to remember.'

He mentioned the same thing with Dr. Denney and Dr. Dietz as well, which just all of this confirms the ongoing impairments and worsening of Mr. Brockman's functioning.

Q. Okay. You also mentioned that -- the neuroimaging in this case. What -- you know, how did the neuroimaging fit into your exercise of your clinical judgment in assessing Mr. Brockman?

05:05:21 **A.** Well, the two MRIs, one in 2018, one in 2021, revealed some brain volume loss, but the more compelling evidence is from the two FDG PET scans and the amyloid PET scan, all of which were consistent with dementia.

Q. All right. Is that your expertise?

05:05:45 **A.** It is not.

Q. And where did you get the information from that it is consistent with dementia?

A. From the reports of the radiologists.

Q. That included whom?

05:05:53 **A.** That included the radiologist who actually read the initial report, Dr. Whitlow, and Dr. Ponisio.

Q. Ponisio?

A. Ponisio.

Q. That's the government's retained neuroradiologist who

05:06:08 in her reports stated that the images were most consistent with early dementia?

MR. SMITH: Objection. That is leading.

THE COURT: And it's testifying.

MR. LOONAM: Done. Withdrawn.

05:06:30 BY MR. LOONAM:

Q. Okay. So what is that, that mosaic, come together, and what does it say to you about Mr. Brockman's level of impairment?

A. Well, if I could also add, the -- his three episodes of delirium, is another factor that goes into my reasoning. So he's had delirium. This has been like every three months in 2021, which again, reflects to me the fragile nature of his brain function, the fragile nature of his cognition. It's associated with a step-wise decline in his performance, in his functioning. So, that's -- that that's another important consideration.

Q. Thank you. In assessing Mr. Brockman's, you know, cognitive impairment, and let's talk about domains now, can you describe what impairment Mr. Brockman has, if any, with respect to orientation?

A. He is not fully oriented. He is not fully oriented to month, to date, to year. He knows his date of birth. He doesn't know his home address. As you heard Mr. Gutierrez say, that he's often confused at home as to -- that he doesn't know that he is home. So his orientation, which was better at earlier testing with Dr. York, for example, he was essentially oriented, but is -- but is now no longer oriented.

So, his orientation reflects a level of confusion.

Q. So, with respect to that cognitive domain, have you observed a progression that's reflected in the test data?

A. Yes.

Q. What about with respect to memory?

05:08:19 **A.** His memory is -- has always been quite poor on testing. What I have found happens more now is that his memory is -- there is more evidence of confabulation, confusion, unable to keep track of task demands for the most part. Sometimes he is able to do that, but other

05:08:47 times, he is not.

So his memory is -- especially for recent events is really quite untrustworthy. Can't tell you oftentimes what happened when, how long ago this was, how many times he was hospitalized, when it happened, when did

05:09:01 I see him last. All of that information gets confused.

Q. And -- and in putting together, you know, your clinical judgment, did you consider that 2019 deposition video and the September 2019 deposition transcript --

A. Yes.

05:09:19 **Q.** -- of Mr. Brockman's deposition?

A. Yes.

Q. All right. What do you make of that?

A. Well, it's a striking contrast to the testing by Dr. York and -- and on -- on face value it's hard to

05:09:35 reconcile those two aspects of his performance.

Seeing the bigger picture, however, now, I believe that -- that what Mr. Brockman was exhibiting in January of 2019 and in September of 2019 were still some relatively well-preserved skills especially with regard to his long-term memory.

05:09:55

He was -- as I understood it, he was describing procedures and products and policies that he had spent decades on, that he was very familiar with. These were overlearned ideas that allowed him to speak fluently and articulately on these topics. However, when he was confronted with exams and tests that he had no prior experience with, that were really new and novel to him, that's when his performance really declined.

05:10:10

Also, Mr. Brockman is a very, very smart guy. He was writing computer code in the 1970s. So the way in which he may dement, so to speak, is -- he is the kind of gentleman who would likely show some well-preserved skills moving into his dementia, unlike others who -- who don't have the cognitive horsepower that he may have had, who might show a more rapid decline or a more rapid decline across multiple domains. Mr. Brockman, in my opinion, because of his innate intelligence and in the case of these depositions his intimate knowledge with the topics that they were involved with, showed some remarkably still intact cognitive functions, that in my

05:10:29

05:10:53

05:11:14

opinion he could never do now. That's -- it is clearly out of his capabilities at the current time.

Q. That is my next question. I mean, wherever he was in 2019, could Mr. Brockman deliver that deposition as he sat here today, present day?

05:11:32

A. Absolutely not.

Q. Sustained attention and vigilance, what impairment, if any, does Mr. Brockman exhibit in the domain of sustained attention and vigilance?

05:11:48

A. Well, he has difficulty staying focused over long periods of time. He has difficulty being able to maintain his attention. He loses attention rapidly. Part of that is, I think, due to the mental fatigue.

I would think -- I think part of that is

05:12:05

simply the fact he is really unable to focus and keep his mind on a topic or a subject matter for -- for what -- for what we would consider normal span.

Q. Okay. What about working memory?

A. Working memory refers to the amount of information

05:12:22

that a person can hold in their head at any given time, like a phone number.

Mr. Brockman does show some skills in that area. For example, his digit span forward typically falls within the average range, but his ability to manipulate

05:12:37

those digits going backwards or in sequence falls below

average. So he has some weaknesses with regard to his -- his working memory.

Q. And what about mental processing speed and reaction time?

05:12:49 **A.** Yeah. So, Mr. Brockman in my opinion is simply slow to process information. He takes more time. Parkinson's disease, you -- it slows a person motorically. It also slows a person cognitively.

And so he is simply -- it takes him longer 05:13:07 to think through problems, takes him longer to think about things, takes him longer to come to answers to questions that are posed to him.

Q. Well, and not only questions posed to him, what about, you know, observing witness testimony and how long 05:13:23 it would take him to process that?

A. Yes, same problem. Same problem.

Q. What about visual spacial abilities?

A. He also demonstrates problems with copying designs, drawing designs, et cetera. These are less relevant to 05:13:40 the issue of competence, but they do speak to simply -- to the nature of his brain function.

Q. What about problem solving and decisionmaking?

A. He also exhibits some difficulties there, although he did do well on a problem -- on one problem-solving measure 05:13:58 that I administered called the Iowa Gambling Test, which

was a little more structured than other problem solving tests that I gave him.

He has some innate, still, problem solving skills. For example, if you ask him common sense kinds of questions like what should you do if you find an envelope in the street that is sealed and addressed and has a new stamp. He can say, 'Put it in the mailbox.'

So some of those kinds of socially constructed solving problem -- problem-solving skills remain intact. But when confronted with a new task that he has to organize himself and think through options, he doesn't do well with that at all.

Q. All right. What is your understanding of the level of complexity of this case that is charged against Mr. Brockman?

A. My understanding is that it is very complicated.

Q. Can you just give us a sense for how complicated it is?

A. Well, it's, from what I understand, a 39-count indictment that involves failure to pay taxes, involves obstruction of justice, involves wire fraud, involves a failure to report income, the FBAR. I think that's the right issue.

Also issues with -- I don't understand this -- buying back bonds that were issued to -- lent

money to buy his company.

So multiple layers of complexity, multiple entities involved, so that it appears to be a very complex case.

05:15:46 **Q.** And do you understand the time frame that's involved?

A. Decades.

Q. And does that matter in assessing Mr. Brockman's ability to meaningfully assist counsel in this case?

A. Yes.

05:16:01 **Q.** And -- and what about the quality of counsel, do you take into account the -- do you measure the quality of counsel in trying to determine whether a defendant is competent to stand trial?

A. No. I wouldn't know how to do that.

05:16:28 **Q.** Do you believe that Mr. Brockman is -- is able to meaningfully assist his counsel?

A. I do not.

Q. Could you just summarize for us why not?

A. Due to the nature of his cognitive impairments, I

05:16:49 believe he would have significant difficulty being able to recall past events accurately, review documents, and provide context to his attorneys.

I think he would have difficulty understanding the complexities of the case, the strategies

05:17:12 of the case. He at times confabulates, meaning he

generates information that's not accurate. He confuses -- as I said, he confuses events that happened in the past, the temporal order of things.

So I think trying to get him to go back and provide some insight and awareness into events that happened years ago, or to understand the ramifications of current decisions, I don't think he's capable of doing.

Q. And some of the current decisions, for example, could Mr. Brockman, do you believe, you know, make a competent decision of whether or not to testify in the case on his own behalf?

A. No. I don't think so.

Q. And do you think he -- you think he could actually take the stand and testify in a coherent way?

A. I don't think so.

Q. Do you think Mr. Brockman has the mental stamina needed to sit through a trial?

A. No, I don't.

Q. And do you believe Mr. Brockman is -- is malingering his -- his -- his cognitive impairments?

A. I don't think so.

MR. LOONAM: One moment, Your Honor.

THE COURT: Yes.

MR. LOONAM: I have no further questions. Pass the witness.

THE COURT: Sure. Cross-examination?

MR. SMITH: Yes, Your Honor, thank you. I'll give counsel a minute.

MR. LOONAM: Yes, thank you. Yeah, thank you. And while I am cleaning up, Your Honor, do you have a -- a sense for how long you and your staff are able to persevere here, and whether we should have a witness in the wings, ready to go?

Because we are -- we are prepared to do that, if the parties are, and if the Court is --

THE COURT: How long, Mr. Smith, do you think you will be on cross-examination. I'm guessing about an hour, hour-and-a-half.

MR. SMITH: Hour-and-a-half maybe.

THE COURT: So I don't think that we are probably -- I mean an hour-and-a-half gets us to 7:00 which is what I -- that is what -- when we are going to be knocking off.

MR. LOONAM: Understood, Your Honor. Thank you.

THE COURT: So this witness should be the last witness of the day.

MR. LOONAM: Thank you, sir.

THE COURT: We will start up again tomorrow morning. And we could stay later, but then I run into

problems. It turns out that we have got AC issues, security issues, so --

MR. SMITH: Understood, Judge.

THE COURT: -- and I didn't really think of all of that when I was looking at working later.

MR. LOONAM: Totally understood. I just wanted to make sure we were prepared for whatever.

THE COURT: We are good.

MR. LOONAM: Thank you, sir.

CROSS-EXAMINATION

BY MR. SMITH:

Q. Good evening.

A. Evening.

Q. Dr. Guilmette, my name is Corey Smith and I'm with the prosecution in this case. I have got a couple of questions I want to ask you.

First, though, I do want to pay you a compliment. I went through your CV, and you have quite the career. I mean, it's quite long, a lot of publications, a lot of presentations in a lot of very complex issues.

One thing that I notice that I wanted to ask you about, isn't it the case, Dr. Guilmette, that your primary specialty is in personal injury and brain injury analysis and cognitive testing of people with those

injuries? Isn't that correct?

A. That is ---

Q. Yeah. Go ahead.

A. That's the majority of cases that I see, in a -- in a forensic context.

Q. Right. And so when I went through your CV, I mean, I counted it up, the number of injury cases, brain injury or other injury that you have done presentations on, and I counted 18. I probably missed a couple. It is probably 20, maybe 21.

But one word I did not see in your CV, and that word is "criminal." You have actually not worked on many criminal cases, have you, Dr. Guilmette?

A. Right. I have not.

Q. Have you ever testified in a criminal case?

A. Yes.

Q. How many times?

A. I believe four.

Q. And those were death penalty cases, right?

A. So one was a competence to stand trial, two were insanity cases, and one was a Daubert hearing that involved the death penalty.

Q. So, you acknowledge, though, there is a difference between a death penalty case where the issue is the IQ of the defendant, whether constitutionally they can be -- is

that right?

A. No. No. That was -- the case that I testified in was -- was a penalty phase, was -- had nothing to do with IQ, was not an Atkins-type case.

05:22:20 **Q.** Okay. It was not an Atkins case?

A. Was not Atkins. No.

Q. So at most you have testified in two or three competency cases, is that right, where you're evaluating the competency of the defendant either to stand trial or

05:22:31 in the death -- or in the penalty phase?

A. I have testified in one competency case.

Q. Okay. One competency case. Okay. And you testified on direct about secondary benefit, right?

A. Secondary gain? Yes.

05:22:46 **Q.** Secondary gain, secondary benefit. Secondary gain, which is when somebody that's being evaluated for competency or cognition, there's a question as to whether they're trying to get some kind of gain and fool the tester, right, that's what secondary gain is, right?

05:23:04 **A.** Yes.

Q. Okay. So what I want to ask you about is the difference between secondary gain in a personal injury situation versus secondary gain in a criminal case.

So in a personal injury-type case, the

05:23:20 objective of the subject, is it not, is to convince the

test taker that they have some kind of energy -- injury, so they can gain something, isn't that right, like a brain injury or something?

They are looking to get something for themselves by feigning the injury that they claim they have? Is that right?

A. Yes.

Q. So the secondary gain is to reach out and get something, maybe money, maybe a settlement, maybe an insurance claim, something like that, right?

A. Yes.

Q. And that plays into their motivation to convince the test taker that they actually are injured and it's the objective of the test taker to find out are they really injured or are they malingering? Is that right?

A. Yes.

Q. Okay. Now, let's talk about a criminal case. Would you agree that in a criminal case the motivation is completely different? It's -- actually it's the exact opposite?

A. Yes.

Q. If the personal injury patient fails, and is actually unveiled to be a malingerer, they simply don't get their payout, right?

A. Yes.

Q. If the criminal defendant fails and is unveiled to be a malingerer, they could go to jail, pay huge penalties and fines, so it's what they're going to lose versus what they're going to get, do you understand that?

05:24:45 **A.** Yes.

Q. Is that -- would you agree with that?

A. Yes. So what you're saying is that the -- are you talking about in a competence-to-stand-trial case?

Q. Right. Right. The motivations are completely

05:24:58 different?

A. Yes.

Q. And your expertise is in personal injury cases?

A. I have an expertise in personal injury cases.

Q. So -- but you do not have an expertise really in

05:25:08 criminal cases? You testified in one criminal case?

A. I testified in one competency.

Q. Competency. I'm sorry. Competency criminal case, you testified once?

A. Yes.

05:25:17 **Q.** Do you know how many times Dr. Denney has testified in criminal cases?

A. I don't.

Q. Would you be surprised to learn it is over 100?

A. I don't have any reaction either way.

05:25:26 **Q.** Do you have any idea how many criminal defendants

Dr. Denney has evaluated for competency?

A. No.

Q. Would it be -- would it surprise you that he testified here last week that it is over 1,000, that he has been doing criminal cases for 22 years?

A. Uh-huh. Okay.

Q. Would that surprise you?

A. Again, I don't have any reaction to that.

Q. So, I mean, I -- I think we can judge for ourselves. Dr. Denney has done over 1,000 criminal cases and you have done one?

MR. LOONAM: Is there a question pending?

THE COURT: That was the question.

BY MR. SMITH:

Q. That is a question. It is.

A. I'm sorry. Could you repeat the question?

Q. So would you agree Dr. Denney -- well, let me rephrase the question.

So a lot of this testing that we're testifying about, that Dr. Denney testified about, what you testified, some of it is mathematical, but some of it requires some judgment?

A. Yes.

Q. The judgment of the psychologist or the neuropsychologist, right?

A. Yes.

Q. So you have to apply your expertise to what you are seeing in front of you and what you are observing; is that right?

05:26:31 **A.** Yes.

Q. So, on one hand we have Mr. Denney, who has done over 1,000 criminal cases, versus your judgement on one criminal case?

A. Yes.

05:26:40 **Q.** Okay. Just want to make sure we're clear on that. And the other thing I want to ask you about before we start getting into the testing, is now your experience -- and granted, it's a long, illustrative career, but it's basically a clinical career, isn't that right?

05:26:56 **A.** When you say basically a clinical--

Q. You have been working as a clinician. That is what you testified on direct?

A. Yes. Okay. Yes.

Q. You have been doing clinical work with patients

05:27:06 coming in, right?

A. Yes.

Q. You haven't done much forensic work, have you?

A. Well, I do do forensic work. I mean what we just described in terms of the civil cases that I have been

05:27:17 involved with, that's forensic work.

Q. The ones you -- the one criminal case was forensic?

A. Well, the -- the personal injury cases, they're all forensic.

Q. Okay. Okay. But you're primarily a clinician; is that right?

A. I do more clinical work than other work.

Q. So what I want to ask you about is, isn't there a big difference between clinical work in the neuropsychology field and forensic work?

A. Yes.

Q. Two completely different; is that right?

A. Yes.

Q. Would you agree that in clinical work the patient comes to you and is telling you about their symptoms, they are taking their tests, and they think there is something wrong, and they want to get better?

A. Yes.

Q. So, they have -- they're motivated to actually be honest with you --

A. Yes.

Q. -- as the clinical psychologist, right?

A. Yes.

Q. In a forensic setting, isn't it the exact opposite?

A. In a -- in a forensic setting you do not take just the word of what the person is telling you. There can be

ulterior motives. You look for other confirmatory information.

So there is a much higher degree of skepticism in a forensic case than in a regular clinical case.

Q. Right. Right. And the way neuropsychologists differentiate between somebody who has generally got a mental decline or is mentally -- not mentally ill, but has cognitive decline and is malingering is we use these validity tests?

A. Yes.

Q. Which you were asked about on direct?

A. Yes.

Q. So I just want to make sure that we're clear on the record here, so you have two kinds of tests, right, you have the cognitive test, right?

A. Yes.

Q. And then you have -- which measure or try to measure the cognitive level of the subject, and in a criminal case, the defendant?

A. Yes.

Q. And the way we determine whether the person is really trying to pass those tests or trying to fake it, as counsel says, is we use these other sets of tests, these validity tests, right?

A. Yes.

Q. Okay. And the validity tests are designed to sort of weed out the fakers, right?

A. Yes.

05:29:21 **Q.** And they tell us how to interpret the cognitive tests, right?

A. Yes.

Q. So if somebody fails a number of validity tests, then you turn to the cognitive test and you say, 'Well, these

05:29:31 are no good; they are unreliable.' Is that how that works?

A. Basically.

Q. Okay. So, isn't it a -- isn't it true that in the neuropsychology field, the consensus is that two failed

05:29:45 validity tests basically tells you you got a faker?

If someone takes a battery of seven validity tests and they fail two of them, you're a faker?

A. Well --

Q. Isn't that the consensus in the field?

05:29:56 **A.** That is generally the consensus, yes.

Q. Okay. So now I want to ask you a little bit about some of the testing. Counsel showed you -- do you still have Exhibit 66? Do you still have that up there?

A. I can see it now.

05:30:18 **Q.** Oh, okay. I want you to have --

MR. SMITH: Can I approach, Your Honor?
THE COURT: Yes.
MR. SMITH: Do you have another copy of this for him?
05:30:24 MR. LOONAM: I just have the one you gave me.
MR. SMITH: Did you give him one when he was testifying?
MR. LOONAM: No. We didn't show it.
MR. SMITH: We will just use the --
05:30:32 THE COURT: You want us to make a quick copy?
MR. SMITH: No, that's okay, Your Honor. I have just got a few questions about it.
BY MR. SMITH:
Q. So if I understand what you said on direct, this is
05:30:40 the article that you said that you rely on in saying that Dr. Denney's scoring of the Victoria Symptom Validity Test was incorrect; is that right?
A. Well, actually it was from his -- from the manual --
Q. Okay.
05:30:55 **A.** -- that he -- that he interpreted a chance range score, and made it a below chance range score.
Q. So what your -- let's see if I understand what you're saying. So on this test, Dr. Denney scored Mr. Brockman at an 8, 8 out of 24 of the hard tests, right?
05:31:15 **A.** Yes.

Q. And the manual and this article says, well, no, that's not below chance, it's actually -- it's -- 7 is what you need, right? You need a 7?

A. Yes.

05:31:26 **Q.** And not to get too deep into the statistics here, but basically what they're saying is if you're in the 5 percent range, you're malingering; if you are above 5 percent, you're in the valid range?

A. Yes.

05:31:38 **Q.** Is that right?

A. Yes.

Q. That's what this article says?

A. Yes.

Q. So, do you know the date of this article?

05:31:48 **A.** 2006.

Q. Yes. So this article is in 2006 written by some, I am sure, very esteemed professors: David Loring, Glen Larrabee, Gregory Lee, and Kim Meeter. Do you know any of those gentlemen and, I guess, one woman?

05:32:05 **A.** I don't know them personally.

Q. All right. But you have heard of who Dr. Larrabee is, right?

A. Yes.

Q. He is well-known in the field?

05:32:12 **A.** Yes.

Q. Are you familiar with an article that Dr. Larrabee wrote in 2014 --

A. I don't know --

Q. -- on the same topic?

05:32:23 **A.** -- that I reviewed the article.

Q. Let me hand you what's already in evidence as Exhibit 123.

MR. SMITH: May I approach, Your Honor?

THE COURT: You may approach.

05:32:30 BY MR. SMITH:

Q. Are you familiar with this article, Dr. Guilmette, written by Laurence Binder, Glen Larrabee, and Scott Millis?

A. Yes, I have seen this article before.

05:32:39 MR. SMITH: It's Exhibit 122. It is already in evidence. Do you need a copy?

MR. LOONAM: If you have one. If you don't, that's fine.

BY MR. SMITH:

05:32:52 **Q.** And this article is written in 2014, correct?

A. Yes.

Q. And in the abstract, I don't know if I can -- whoops, wrong way. 123. I'm sorry. It is. I heard that. It's 123. I got my numbers backwards. 123.

05:33:07 Government's Exhibit 123. Do you see

where I put it on the screen there? And what Dr. Larrabee says in --

A. Excuse me, can you shrink it? It's the --

THE COURT: The monitor is a little off.

05:33:21 BY MR. SMITH:

Q. Is that better?

A. No. Shrink -- can you shrink it? There we go.

Q. How is that?

A. That's better.

05:33:26 **Q.** You have a copy there of the abstract.

A. That's true, I do.

Q. And what it says in that abstract, what this article -- at least in the abstract -- we will go to the body of the article.

05:33:39 What they're saying is that that .5, .05, 5 percent cutoff for invalid is too low?

A. Uh-huh.

Q. That actually should be .2, 20 percent. So if you score on the test at 20 percent -- or, I'm sorry, below 20

05:33:56 percent, you're a malingerer, isn't that what that says?

A. Yes.

Q. So, turn to page four, Dr. Guilmette.

A. Okay.

Q. And, again, can you see that on the screen? I know

05:34:23 it's a little bit off. You have it there?

A. Right.

Q. That's the paragraph I want to draw your attention to. It says, "Therefore, we recommend..."

A. Yes.

05:34:31 **Q.** So, Dr. Larrabee in 2006 said one thing, but then ten years -- you know, eight years later, he changed his results and said -- changed his analysis and said, a P-level -- that's the probability we're talking about, you're in the tail end there -- of 20 percent is

05:34:53 acceptable for a failed malingering -- to score it as malingering, a failed validity test; isn't that what he says?

A. Yes. That's what the article says.

Q. So that's different than what -- the article that

05:35:06 counsel showed you on direct?

A. Yes.

Q. And that's how Dr. Denney scored the Victoria Symptom Validity Test, isn't it? The 8 is in the 20 percent, Dr. Denney's score of 8 for Mr. Brockman is in the bottom

05:35:21 20 percent?

A. Yes. Yes.

Q. So that's a fake?

A. Well, however, the most recent consensus conference statement on the neuropsychological assessments of effort,

05:35:35 malingering and response bias that I mentioned earlier in

my direct testimony, published just this Spring from the American Academy of Clinical Psychology did not report this. There is no consensus in the field about what the cutoff should be with regard to probability levels.

05:35:49 **Q.** Right. Right. And we are going to get to that paper in a minute. But it just says there is no consensus. But Dr. Larrabee indicates in his recent article, relatively recent from 2006, that that's his suggestion, that is his recommendation that that score below 5 percent, is the --

05:36:10 all the malingerers are below, way in the bottom at 5 percent, that is incorrect. If you are in the 20 percent you should score it as a fail?

THE COURT: I think you said 2006. I think you meant 2014.

05:36:21 BY MR. SMITH:

Q. This article is 20 -- he said that in 2006. But now he is saying in 2014 that that is too low, that that has to be at 20 percent or less. Dr. Larrabee is saying that now in 2014, right?

05:36:34 **A.** Yes.

Q. And the 2020 -- the 2021 American Academy of Neuropsychologists consensus paper does not contradict that, does it?

A. It doesn't support it either.

05:36:46 **Q.** That wasn't my question. I am -- I know you have

said it doesn't support it, but it doesn't contradict it either?

A. I would argue that it does because otherwise it would state that 20 percent probability of chance performance should be the cutoff and it doesn't say that.

Q. So because it doesn't affirmatively say that, then that means it says -- that Dr. Larrabee is wrong?

A. It says that there is not a consensus in the field that would support Dr. Larrabee's contention.

Q. Okay. So it's a matter of judgment? How to score this test is a matter of judgment, there is not a consensus, right?

A. There is not a consensus.

Q. So Dr. Larrabee said one thing in 2006 and that's -- that's what you chose to follow?

You said, Well, Dr. Larrabee says in 2006, Dr. Denney's scoring of the Victoria Symptom Medical Validity Test -- I am -- it is hard for me to get these terms out, the VSMT -- Dr. Larrabee said in 2006 that that's a fail, so you chose that analysis to apply to Dr. Denney and said Dr. Denney is wrong, it's a fail, but in 2014 Dr. Larrabee said the exact opposite, you chose not to choose that analysis?

A. I was still going by the -- by what the manual suggests.

Q. Which is contradicted by Dr. Larrabee, who wrote the first article?

A. But that still does not mean -- there is still not a consensus. There is still not a consensus. If the -- if the consensus conference said, you know what, Larrabee is right, you know, we will just make 20 percent, you know, that's it, we're good with that, but they didn't say that.

Q. I get -- I understand that. Let me ask this a different way.

I understand there is not a consensus. That is not what I am asking you.

A. Okay.

Q. Dr. Guilmette, what I am asking you is, it's not a consensus and there is difference -- there is different opinions -- there is one opinion in 2006, and there is one opinion in 2014; you chose the opinion in 2006, that allowed you to conclude that Dr. Denney improperly scored that test. Isn't that what happened?

A. I think Dr. Denney was incorrect in using that cutoff.

Q. That is your opinion --

A. Yes.

Q. -- based on the 2006 article of Dr. Larrabee?

A. Based on the -- on the fact that in the field, .05 is generally the standard, and that was not contradicted by

the consensus conference.

Q. All right. We will move on.

A. Okay.

Q. So the other thing you said about Dr. Denney on direct, and one of his tests, the Green NM -- NV-MSVT test, and this is Government's Exhibit 2, counsel showed you this chart here. Is that on your screen?

A. Yes.

Q. It's from Dr. Denney's October report. Do you remember that?

A. Yes.

Q. And this was Dr. Denney's -- excuse me -- this was Dr. Denney's graphing of Mr. Brockman's scores, because this test has a lot of subtests, right?

A. Yes.

Q. They go from easy to hard?

A. Right.

Q. So what Dr. Denney did is he scored those and he put them on this graph. And so we have the IR, the DR, the CNS, and the DRA, those are all easy tests, right?

A. Yes.

Q. And then you got the harder tests at the end?

A. Yes.

Q. Right. And so what Dr. Denney did is he plotted those scores and he said, 'Well, you know, it's sort of

inconsistent with what we generally see, these dotted lines going across. For genuine demented patients, there is more of a smooth curve, but Mr. Brockman is not in a smooth curve, so it's not a typical profile.' That's what
05:40:26 Dr. Denney said, right?

A. Yes.

Q. Okay. And counsel asked you about these groups down here that Dr. Denney compared Mr. Brockman's scores to. You see that?

05:40:41 **A.** Yes.

Q. The dotted lines. And that's what Dr. Denney is comparing Mr. Brockman's scores to are those dotted lines of these other people, right?

A. Yes.

05:40:50 **Q.** Now, counsel asked you where those groups came from and he asked you whether or not Dr. Denney just picked those groups and just made it all up.

Remember him asking you that?

A. Well, I --

05:41:00 MR. LOONAM: Objection, misstates the question.

MR. SMITH: I'll rephrase it, Your Honor.

BY MR. SMITH:

Q. Let me just get right to it. In fact, of all these groups, these dotted lines that Mr. Brockman's scores are
05:41:10 being compared to, Dr. Denney only picked one of those

groups; isn't that true?

A. I don't know how many he picked.

Q. Well, how many of these have his name on them?

A. One.

05:41:21 **Q.** And these other groups; mixed dementia, where my pen is pointed, and -- Dr. Cohen, and there is another one down here. Doesn't the -- doesn't the exam give you groups to compare scores to?

A. Yes.

05:41:39 **Q.** And isn't that what this is?

A. Yes.

Q. So, Dr. Denney did not pick these groups? He didn't pick all of them?

A. I don't know how many he picked.

05:41:49 **Q.** Well, he didn't pick all of them, did he?

A. I don't know. So, are -- are you saying that because it says Dr. Cohen on the -- on the second line, that that meant that -- that Dr. Cohen chose? I am not quite sure.

There is no way of knowing just looking at

05:42:07 this which groups Dr. Denney actually went in and chose himself, versus which groups were chosen by the program.

Q. Okay. Well, that's a good point. So let me ask you about that. When you say go in and choose the groups, these are groups of patients that the test taker can

05:42:24 choose from to compare his patient's score to, right?

A. Yes. Yes. There is that option.

Q. Right. So the test taker goes into the program and the program has got all these test scores of different groups of people and they say let's compare to, let's see, mixed dementia group who passed NN -- NV-MSVT Criteria A.

And these groups of patients, these are patients, and these analyses and scores of these patients, they're in the program, right?

A. Yes.

Q. Dr. Denney didn't go out on the street and pick up some people and test them and put them in the chart, right?

A. Not those.

Q. That's what I am asking you. These are test results that are built into the program, and then Dr. Denney went in and looked for, apparently, in this case, mixed dementia group folks.

And if you could turn to the next page.

A. I don't have the next page.

Q. Oh, I'm sorry, I forgot you didn't have it up there. Let me put this up here.

This is the other test and in Dr. Denney's report, the Green's MSVT, and, again, we have these groups here that he is comparing to, and in this case we got mean age 73, mean age 76.

So the program gives you the option of who to compare your patient's test scores to, right?

A. Yes.

Q. Dr. Denney didn't test these people?

05:43:54 **A.** Not these people.

Q. And he didn't pick them up out of the street, right?

A. No.

Q. They are not in his practice in Missouri, right?

A. Not these people, no.

05:44:02 **Q.** They're in the exam. I'm sorry. They're in the program, right?

A. Yes.

Q. Then you click the box of which ones you want that look like your patient?

05:44:09 **A.** Yes.

Q. And Dr. Denney picked people who were 76, 76 and with dementia?

A. Yes.

Q. Okay. Which is -- wouldn't you agree that that's a

05:44:19 suitable comparison to compare to Mr. Brockman?

A. Yes.

Q. Okay. All right. So, now, let's talk about your tests. So you mentioned it on direct, the Iowa Gambling Test.

05:44:38 **A.** Yes.

Q. Do you remember talking about that?

A. Yes.

Q. Can you just explain for the Court real quickly what is the Iowa -- what does the patient have to do when you administer the Iowa Gambling Test?

A. So in the Iowa Gambling Test a patient is shown essentially four decks of cards, and the individual chooses a deck, or chooses a card from the decks, and the card that they choose will either reward them money, or will take money away from them.

And so what the individual has to do is to try to max -- and the decks have various values in terms of how much -- which decks are more advantageous to choose versus which decks you will lose more money from.

And so the individual has to -- they choose a deck, a card, and then they have to try to figure out based upon how much money they make, or how much money they lose from any given card in each deck, which decks are more advantageous to continue to play from.

Q. And isn't it true, Dr. Guilmette, that the idea of the test is to test the patient's decisionmaking skills, and risk/reward, and almost an executive function?

A. Yes. Excuse me. It's -- it's very much -- yes, a risk/reward kind of balance is what the patient is trying to do.

Q. And up on the screen, do you see what I have got up there?

A. Yes.

Q. Is that your test scores on Mr. Brockman in the Iowa Gambling Test?

A. Yes.

Q. From your July exam -- so the record is clear, from your July exam, you administered the Iowa Gambling Test?

A. Yes.

Q. Which is not a validity test, right?

A. Correct.

Q. It's a competency test?

A. Competency?

Q. Cognitive test. I'm sorry, I misspoke. Cognitive test?

A. Yes.

Q. And you administer this score, and Mr. Brockman passed the test, didn't he?

A. He passed. Yes, he did, basically.

Q. And he got a score of -- of 50 -- of -- I'm sorry, 49, that was his total score, right?

A. Yes.

Q. And each one of these net one, two, three, four, five -- these are the different times that he goes through

the test? Five times?

A. Yes.

Q. 20 choices, five times, see how he does.

And on all of these tests he scored above

05:47:15 44, except the last one he had a raw score -2 and he scored a 43?

A. Correct.

Q. Which is still in the unimpaired range. Right?

A. Yes.

05:47:24 **Q.** So, just to be clear, let's look at what the manual says. Are you familiar with this?

A. Yes.

Q. So, for the record, it's the Iowa Gambling Test manual. What I want to show you, Dr. Guilmette, is what

05:47:42 the manual says about scoring, when talking about manuals and tests and how we are supposed to score these tests. I have highlighted the section I want you to read.

MR. LOONAM: Your Honor, while the witness is reading, I note we don't have a copy of this.

05:47:55 MR. SMITH: Yeah. I only have one. I only have one copy. We can get you a copy. It's on the screen.

THE COURT: Yeah. If anybody wants us to make copies to speed things up, I can have someone do that.

BY MR. SMITH:

05:48:10 **Q.** So, the part of the score -- the manual that tells

you how to score or how to interpret the scores, it says that "T scores higher than 44 at a decisionmaking level or higher (the top range of neurology-impaired patients) those patients should be considered unimpaired."

05:48:29 **A.** Yes.

Q. And, so, Mr. Brockman's score was well above 44. Right? He scored a 49?

A. Yes.

Q. You didn't put that in your report, though, did you,

05:48:44 Dr. Guilmette?

A. I didn't put that quote, no.

Q. No. No. You didn't put his score of 49 or that he tested unimpaired in the Iowa Gambling Test. You did not put that in your report, did you?

05:48:54 **A.** I thought I put all of these scores in my report.

Q. Well, let's look at your report. So, this is Defense Exhibit 19, Page 52. Can you see that?

A. Yes.

Q. Iowa Gambling Test?

05:49:15 **A.** Yes.

Q. You want to show me where in your report you put in that Mr. Brockman scored a 49, which puts him in the unimpaired range?

A. I don't -- Do you have the actual raw scores or

05:49:30 the -- There should be a table of scores that I think that

I included.

Q. That's what I just showed you. This is the table, sir.

A. No. No. No. I'm sorry. The table in my report.

05:49:46 **Q.** You mean this table?

A. Yes.

Q. And you put the 49-T. Right?

A. Yes.

Q. Did you put in your report that that means he's

05:49:53 unimpaired?

A. No.

Q. So, you just put the score and you didn't interpret it?

A. No. I did interpret it. I mean, I said that he --

05:50:03 that his performance -- I don't remember the exact words that I said, but I acknowledged his performance on this test.

Q. But you didn't say he's -- this test indicates he is unimpaired? That's not in the report?

05:50:18 **A.** Right. I did not say that.

Q. As a matter of fact, what you did, though, is you said that you -- you focused on the last test, where he got a -2, of the five subtests of 20 cards -- what you did is you simply focused on the one part of the test where he

05:50:36 came out with a -2. Isn't that right?

A. I don't think so. I also say that he -- that he was able to generate -- his overall performance reflected that he generally made advantageous choices to increase his winnings and avoid losses. So, I am describing his performance.

Q. What I have highlighted here or what you highlighted -- didn't you say in this report, "However, in the last trial of 20 cards, net five" -- that's the last trial -- "his decisionmaking became disadvantaged, perhaps secondary to fatigue. He began to choose cards from the decks," so on and so forth, and then you go on to say that he took 25 minutes to complete the test. "He likely performed more proficiently on the test with 20 questions because it was more structured."

Nowhere in there, Dr. Guilmette, do you say the overall test score indicates he's unimpaired; isn't that correct?

A. Yes. That's correct.

Q. And, instead, what you did, you simply focused on the one subtest where he underperformed. Isn't that what you did?

A. I -- I am describing the test as I saw it.

Q. Okay. So, now, you were also asked some questions on direct about coaching.

A. Yes.

Q. That's a broad term. Wouldn't you agree that in the field of neuropsychology that it's also improper -- or the literature suggests that it's improper to prompt the patients or suggest answers or sort of edge them a little bit in a certain direction like, 'Well, this is a real easy test. You should do good on it.' That's not really coaching, but it's sort of like edging him in a certain direction. Would you agree that that's not appropriate in the field of neuropsychology?

A. As you described it, I would agree with that.

Q. So, just so we're clear: Are you familiar with Grant Iverson?

A. Yes.

Q. And who is Grant Iverson?

A. He is a well-known neuropsychologist.

Q. And are you --

MR. SMITH: Yeah. We are going to mark this article for identification. Where are we? 161? "Ethical Issues Associated with the Assessment of Exaggeration."

May I approach the witness and give him a copy?

THE COURT: You may.

BY MR. SMITH:

Q. I just want to draw your attention, Dr. Guilmette, to one thing that Mr. Iverson says in his article about

"prompting," which I think is probably a more accurate term than "coaching," don't you think?

A. I don't know what you're referring to exactly.

Q. Prompting -- prompting patients on how to take tests.

05:53:57 Professor Iverson says: "Warning or prompting patients immediately before taking the effort test, it is appropriate to warn patients that methods for detecting exaggeration and poor effort are part of the evaluation process. It is not appropriate to warn or

05:54:11 prompt the patient immediately before the test is administered." Isn't that what he says?

A. Yes.

Q. And that is generally accepted in your field, is it not --

05:54:19 **A.** Yes.

Q. -- not to prompt patients?

Let's look at some of your tests. I think you -- you talked about this. Well, actually -- wait a minute. Before we get to the tests:

05:54:43 You have already mentioned the American Academy of Clinical Neuropsychology 2021 Consensus Statement. And I have got some copies for counsel. I want to ask you something that's in that consensus statement. Is that the one that you have been talking

05:54:59 about?

A. Yes.

Q. Yeah. Okay.

MR. SMITH: And if I may approach?

THE COURT: You may approach.

05:55:09 MR. SMITH: This will be easier probably than the monitor.

THE WITNESS: Oh, you gave me --

MR. SMITH: Yeah. It's two because it's so thick. And we are marking this for identification as 162. 05:55:21 It's the 2021 American Academy of Clinical Neuropsychology 2021 Statement on Validity Assessment.

BY MR. SMITH:

Q. And, again, I just wanted to draw your attention to one part of this. It's Page 1069. I may take this off. 05:55:55 It will be easier to put it on the screen.

Isn't it the consensus that practices -- what the consensus says is that you are supposed to follow the rule book in how to give the test and not depart from the rule book and not -- and, if you do, that can result 05:56:28 in more sophisticated forms of feigning. Isn't that what the consensus said? Do you see that paragraph?

A. Yes.

Q. So, both the American Academy of Clinical Neuropsychologists Consensus Statement and Professor 05:56:53 Iverson -- isn't it true what they're saying is you've got

to be careful when you're giving a test of sort of prompting the or -- the patients, prompting the patients, or sort of suggesting how they should handle the test? Isn't that what they're saying?

05:57:07 **A.** Yes.

Q. Okay. So, let's look at a couple of your tests from your July examination of Mr. Brockman.

The first test, the Rey-15 test -- and if we could just switch for a second to the -- This is

05:57:20 Exhibit 124 that was introduced when Dr. Denney was testifying. This is the blank test sheet of the Rey-15 test.

This is the Rey-15 test. Right, Dr. Guilmette?

05:58:11 **A.** Yes.

Q. And so -- Just if I could have a second to get to the page of your report.

This is -- you administered this test in July, when you examined Mr. Brockman. Right?

05:58:22 **A.** Yes.

Q. And what the test-taker does is you -- you show this to the patient, and then you take it away and you ask them to draw that?

A. Yes.

05:58:33 **Q.** And then there is another part where they then are

given a sheet with the symbols and some other symbols. That's the recognition part, and they are supposed to circle as many as they can?

A. Yes.

05:58:46 **Q.** And from your test data, this is the recognition portion. It doesn't all fit. We can maybe back it off. Do you recognize this? I mean, that hand, that's you?

A. Yes.

Q. And this is the recognition portion?

05:59:00 **A.** Yes.

Q. So, as you testified in direct, though, what you did was -- he didn't do really well on the test. He drew that little -- that little symbol, and then you readministered the test a second time?

05:59:16 **A.** I don't follow you. He -- he drew what little symbol?

Q. All right. So, let me ask it a different way.

When you administered this test to Mr. Brockman in July, he didn't do well on the test, and

05:59:27 then you showed him the test again and you let him have a second chance. Isn't that what you did?

A. He passed the test. I just gave it to him again to test the limits, to see if that would make any difference. But his first performance was valid.

05:59:49 **Q.** Let's look at your -- do you have your report

there --

A. Yes.

Q. -- which is -- I think this is 19, Defendant's Exhibit 19. Let's look at what you put in the report.

06:00:06 Oh, this is what I wanted to show you. Before I do that:

You gave it to him twice. Here is Trial 1 where he is supposed to draw the symbols that -- Just so we will be clear: These are the symbols?

06:00:23 **A.** Yes.

Q. You take it away. You say, 'Okay. Draw what you saw'?

A. Yes.

Q. And that's what he drew?

06:00:28 **A.** As I said, he initially wrote "ABC," and then erased it and drew those figures, and then drew -- and then wrote "123," "123," "123."

Q. And, in your mind, that's a pass?

A. It is a pass. That, in conjunction with the

06:00:43 recognition test or with the recognition work, is a pass.

Q. And then you gave him the test again, Trial 2?

A. Yes.

Q. And he said, "I'm at a loss"?

A. Right.

06:00:52 **Q.** And that's a pass, too, I guess?

A. I didn't -- because I had -- he had already had it once. That was breaking standardization, to give it to him right after. So, I did that looking at more qualitative information. You know, if I gave him more time, would that make any difference? And, in fact, it obviously did not. But he passed it the first time around.

Q. Well, isn't there in the manual a calculation that you're supposed to do to determine whether it's a pass or a fail? The true positives minus the false positives minus the inclusions?

A. So, as we had -- as I had testified earlier, the article that I relied on to determine the various -- There are two scores recommended for individuals who are over the age of 60 and with possible dementia. There is a combination score, and then there is what the authors describe -- the Fazio, et al -- the authors describe as, again, the pathognomonic sign of a disingenuous performance, and that is a series -- there are three decisions or three characteristics of a person's profile.

Mr. Brockman -- and so -- and, so, Mr. Brockman's performance is within the valid range based upon those recommendations by Fazio, et al.

Q. We are going to get to Fazio's article in a second, but what I am asking you about is: On this test that's

now on the screen, when you administer the test, aren't you supposed to do a calculation to determine if it's a pass or a fail, the true positives, minus the false positives, minus the inclusion -- the inclusions, the
06:02:45 stray marks?

A. Can I look at my notes?

Q. Yeah.

A. Yes. So, the -- so, the -- the combination score -- which is, I think, what you're referring to --

06:03:16 **Q.** That's right.

A. -- yes -- is recognition true positives, minus recognition false positive, minus intrusions. So, that's 5 minus 3 minus 1.

Q. Right.

06:03:26 **A.** So, with a score of 1.

Q. Right.

A. Okay. Again, so that is -- a score of one or fewer was found in 8.7 percent of Fazio's sample. Fazio -- he -- I know Dr. Denney is claiming that 2 is the cutoff.
06:03:43 The article never states that 2 is the cutoff.

And then there is the pattern analysis. The pattern analysis is a recall score less than 3, a true positive score less than 3 or a false positive score greater than 5. Now, Mr. Brockman doesn't meet any of
06:04:03 those criteria. This is the -- what I just described in

terms of the pattern analysis is a -- is a perfectly valid pattern of scores.

Q. All right. Well, let's just walk through that a little bit.

06:04:15 So, it's 5 minus 3, which is 2, minus the inclusions --

A. Intrusions.

Q. -- I'm sorry -- intrusions, which are the stray marks. So, do you count that as an intrusion, that mark?

06:04:29 **A.** The mark?

Q. This mark here.

A. Yes.

Q. So, that's a 1?

A. Yes.

06:04:34 **Q.** So, it's 5 minus 3 minus 1, which is a 1. So, he has got a score of 1?

A. Yes.

Q. And then what you are doing is not -- you're comparing that to patients with dementia?

06:04:45 **A.** Yes.

Q. So, in scoring Mr. Brockman on this validity test, you are scoring him against patients with dementia?

A. Yes.

Q. So, isn't the point of the testing to determine if he

06:04:57 has dementia?

A. That's not the point of this test.

Q. No. No. No. The overall test battery. The reason you were conducting any tests was to determine if Mr. Brockman had dementia?

06:05:07 **A.** Yes.

Q. So, you're presupposing dementia to score the test to see if he has dementia?

A. I am scoring this in a way that I think is most appropriate, given Mr. Brockman's history, performance on 06:05:20 other measures, my observations, neuroimaging data, et cetera.

Q. Go ahead. I'm sorry.

A. No. That's all.

Q. That's what I wanted to get to.

06:05:31 So, you're looking at the other information you were given about Mr. Brockman, making a judgment in your professional opinion that he has dementia, and then scoring the tests as if he has dementia?

06:05:45 **A.** Let me actually -- if I may.

Q. Yeah.

A. I just want to check.

Actually, as I now -- as I look at the Fazio article again, actually these, what I just 06:06:06 described, are simply what Fazio, et al, described as the

adjustments to work with an elderly population. So, this is -- this, really, essentially is the way you should score this for individuals over the age of 60.

Q. Okay. All right.

06:06:24 **A.** So --

Q. We are going to get to the October test. You did the same test in October. Right?

A. Yes.

Q. Okay. So, the next test I want to ask you about in

06:06:36 July was the A-Test. And you also scored that test as a pass. Right?

A. Yes.

Q. And didn't you do the same thing on that test? And we can put your test data on the screen. Do you recognize

06:06:52 this --

A. Yes.

Q. -- the 7-13, Mr. Brockman's -- this is the test you administered?

A. Yes.

06:07:01 **Q.** And didn't you say in your report that he initially fell in the invalid range, and then you retested him?

A. Yes.

Q. And you gave him another test because you felt, well, he didn't do well enough the first time?

06:07:15 **A.** I thought because he had lost track of the

directions, lost track of the instructions; and, so, the test was not valid.

Q. So, that's your judgment, that the test was not valid --

06:07:26 **A.** Yes.

Q. -- in your professional opinion --

A. Yes.

Q. -- doing one criminal case?

A. Seeing thousands of patients.

06:07:33 **Q.** Okay. But isn't that determination informed by the evidence you have been given by the defense and the other information that you have been given by all the other doctors' reports, that he, in fact, has dementia?

A. My decision was informed by my observations of the

06:07:52 patient, by looking at the -- his exam from May with Drs. Denney and Dietz. I am sitting there with the patient. I am looking at what he is doing, at -- at how he's responding to the -- to the stimuli. He looked out of it. And, so, a test can't measure what you want it to measure

06:08:18 if the person has lost track of what the instructions are.

Q. Dr. Guilmette, is it at all possible that your opinion that he looked out of it is influenced by Mr. Brockman's motivation not to be prosecuted in this case? Did you consider that?

06:08:33 **A.** Yes.

Q. But you still think he just looked out of it; so, you let him do the test again?

A. When I queried him about what he was thinking or what was going on in his mind during this test, as you can see from his comments, his comments are -- they reflect confusion, that he has lost track of the task demands of the test. So, I did not think it was an accurate reflection of his actual performance of what he could do on this test.

MR. SMITH: And just a housekeeping matter, Your Honor. The test score we're just marking for identification as 163.

THE COURT: Okay. You want to move to admit it?

MR. SMITH: No. No. These are just to -- I'm just marking for identification. It is just the test score, the test sheet.

BY MR. SMITH:

Q. But that determination, Dr. Guilmette, is based on nothing more than what Mr. Brockman told you sitting in the conference room when you're giving the test, isn't that true?

A. It is based on his history, the fact that he had had a delirium episode just the month before, the neuroimaging data. It is not just -- just one snapshot, one moment in

time --

Q. Uh-huh.

A. -- that -- with a vacuum of any other information.

Q. Right. And some of that information is information that's been provided to you by these doctors, like Dr. York, Dr. Yu, Dr. Jankovic, Dr. Pool that evaluated him in 2019; is that right?

A. Yes.

Q. And that influenced your judgment in deciding whether Mr. Brockman is actually taking the test or if he is trying to fool you and say, 'I am at a loss. I don't know what's going on here'?

A. That's too simplistic a description. You're saying that my -- my only view of Mr. Brockman was based on those evaluations that you just described.

Q. Well, no. I am saying they are part of it.

A. Yes.

Q. You had a lot of things to look at.

A. Yes.

Q. But part of what you looked at were the doctors that evaluated Mr. Brockman in 2019?

A. Part of it, yes.

Q. We are going to come back to those doctors in a minute.

Now, I want to move to -- We are done with

July. Let's move to October. Let me ask you about -- and that's your report --

A. Can I get some water?

Q. Yeah. While you're getting some water, I am going to ask you about Exhibit 22, your October report.

THE WITNESS: Thank you.

BY MR. SMITH:

Q. Do you have that up there?

A. Yes.

Q. I just want to ask you about some of the validity tests you did in October.

The first one I want to ask you about is the Medical System Validity Test, which we've heard a lot about. You were asked a lot about Mr. -- Dr. Denney's administration of this test on direct. Do you remember that?

A. Yes.

Q. And you performed the exact same test -- I am going to mark this. This is your test scores from your October 2nd exam. And we're at 164.

MR. LOONAM: Do you have a copy of this?

MR. SMITH: It's -- we got it from you. It's the only copy I've got. This is what you sent to us. This is his test results.

MR. LOONAM: In discovery?

MR. SMITH: Yeah. Yeah. I don't have another copy.

BY MR. SMITH:

Q. I just want to ask you about how you scored this test, Mr. Guilmette -- Dr. Guilmette.

So, I think you were asked a little bit about this on direct. Again -- and we looked at the chart that Dr. Denney did. You have the subtests, IR, DR, CNS, PA, FR across the top. Right?

A. Yes.

Q. You've got the easy tests and then the hard tests. Right?

A. Yes.

Q. And in looking at that those tests, you have to determine whether it's a pass or a fail. Right?

A. Yes.

Q. And you do a calculation -- if it's a possible Genuine Memory Impairment Profile, right --

A. Yes.

Q. -- then you have to do an additional Step 2 calculation to determine if it actually is a GMIP or if it's not a GMIP. Right?

A. No. You have lost me.

Q. Okay. Let's turn the page.

Down at the bottom, do you see that?

A. Yes.

Q. Isn't that the second step of the -- you talked about this on direct. If it's a possible Genuine Memory Impairment Profile, then you have to do this secondary calculation, if you have poor -- to determine whether its poor and consistent effort are identical by the following score patterns and both Criteria A and B are met. Right? Are you familiar with that?

A. Yes.

Q. All right. So, if you have a bunch of fails like Mr. Brockman had -- excuse me -- that indicates a Genuine Memory Impairment Profile, you are supposed to do the secondary calculation down at the bottom of the page. Right?

A. The -- the advanced interpretation profile, or the advanced interpretation program, was the one that generated the possible general memory impairment profile.

Q. Right.

A. So, that's what -- that -- that calculation is done by the -- by the program.

Q. Right. But, after you get the possible Genuine Memory Impairment Profile, to determine if it actually is genuine, you have to do this calculation here?

A. No.

Q. So, you don't -- that's not what this says?

A. Well, I -- I did that, anyway.

Q. Yeah.

A. And, in fact, and -- and Mr. Brockman still generated the -- the Genuine Memory Impairment Profile.

06:14:28 **Q.** Okay. Well, let's walk through it. Criterion A -- well, let's start from the beginning.

If both Criteria A and B are met, right, then it's an implausible result?

Criteria A, IR, DR or CNS are below 85

06:14:54 percent, and Mr. Brockman's IR, DR, and CNS are below, or at least two of them are below 85 percent?

A. Yes.

Q. That is why it says fail/fail?

A. Right.

06:15:07 **Q.** So Criteria A, check, that's done, right?

A. Yes.

Q. So now you go to Part B. You have to have A and one of the five subparts of Part B, right? Isn't that what this says?

06:15:21 **A.** I don't -- this is a -- this is done by the Advanced Interpretations Program.

Q. Right. Right. No, I understand. Let's walk through it. Okay?

A. Okay.

06:15:31 **Q.** Part B, any of the following are met: The mean of

the easy MSVT subtests is not at least 20 points or higher than the mean -- well, I'll grant that's not met, okay?

A. That is right.

Q. Well, I want to direct your attention to Number 4. IR minus DR is greater than or equal to 15.

Do you see that?

A. Yes.

Q. Where my pen is pointing?

A. Yes.

Q. So if that is met, then you have A is met, B is met, and you have an implausible profile, isn't that right? Isn't that what that says?

A. Yes.

Q. Right. So IR minus DR, greater than or equal to 15, simple, elementary school math, right? IR is 90, DR is 65. What is 90 minus 65?

A. 25.

Q. Is 25 larger than 15?

A. Yes.

Q. Criteria B is met, correct?

A. That's -- yes. That's what that says.

Q. So, according to this test, Mr. Brockman failed this validity test, isn't that right?

A. It would appear so.

Q. Okay. Another test I want to ask you about that you

administered is the Rey-15 test, which you did in July, but you also did it in October, right?

A. Yes.

Q. And I probably lost my sheet. Here it is. When I was --

06:17:24

MR. SMITH: Already been in evidence as 124, Your Honor.

BY MR. SMITH:

Q. It is this test, right, just so everybody is on the same page?

06:17:30

A. Yes.

Q. It is this test.

And you have been mentioning the Fazio article, so let's -- which guides you in the neuropsychology field on how to score these tests, right?

06:17:42

A. Yes, this test.

Q. This test. That's right. This test.

MR. SMITH: And I have copies, Your Honor.

MR. LOONAM: Thanks.

MR. SMITH: I also have a copy -- I forgot I also have a copy of that test sheet.

06:18:13

MR. LOONAM: What did you mark that?

MR. SMITH: I haven't marked this one yet.

MR. LOONAM: No, the test sheet.

MR. SMITH: Oh, I can tell you. Hold on one

06:18:25

second.

MR. LANGSTON: 164.

MR. SMITH: You got it? Thank you.

MR. LOONAM: Thanks.

06:18:36 MR. SMITH: So this article we're going to mark as 165. This is the Fazio article that there has been some testimony about. If I may approach, Your Honor.

THE COURT: You may approach.

MR. SMITH: I will give the witness a copy.

06:18:46 THE WITNESS: I have a copy.

BY MR. SMITH:

Q. You do?

A. Yes.

Q. Okay. It is just for marking it for identification, 06:18:56 so this test, what Fazio says, it's on page -- if I can read this, page 6. I think that's page 6. Yeah. This is the passage I want to draw your attention to, Dr. Guilmette.

A. Okay.

06:19:25 **Q.** And --

MR. LOONAM: Which page are you on? I'm sorry. Page 6?

MR. SMITH: Page 6, yeah.

MR. LOONAM: Thanks.

06:19:33 BY MR. SMITH:

Q. This is what we were talking about, true positives minus false positives minus intrusions, right?

A. Yes.

Q. This resulted in scores ranging from 18 to -- negative 18, plus 15. Scores of less than 2 were uncommon in only 87 percent of the sample, so on and so forth, produces scores of negative 2 of all ages 60 plus.

And then if we go to the top, this chart here that I am pointing at right here --

A. Yes.

Q. -- this tells you that if you're under zero, that only 3.9 percent of the test takers were in that range; is that right?

A. Yes.

Q. Okay. So let's -- enlightened by Professor Fazio, let's look at how Mr. Brockman did on this test. Do you recognize this?

A. Yes.

Q. This is Mr. Brockman's test sheet, right, from October when you did the Rey-15 test, right?

A. Yes.

MR. SMITH: I'll mark that as 166, again for demonstrative purposes, Your Honor.

MR. LOONAM: Which one is this?

MR. SMITH: This is --

MR. LOONAM: Oh, different article.

MR. SMITH: No. No. This is the test.

MR. LOONAM: Thanks.

BY MR. SMITH:

06:21:00 **Q.** And then there is a second part of the test, right, Dr. Guilmette?

A. The recognition part?

Q. Yeah.

A. Yes.

06:21:06 **Q.** Let's look at that. Do you see that?

A. Yes.

Q. And you have actually -- this is your writing here, right?

A. Yes.

06:21:21 **Q.** True positives, false positives, four, four?

A. Yes.

Q. Right? So Professor Fazio's calculation is true positives, minus false positives, minus intrusions, is how you score the test, right?

06:21:34 **A.** For the combination score.

Q. The combination score, yes. Four minus four is zero?

A. Yes.

Q. And then you have to look at this part of the test?

A. Yes.

06:21:49 **Q.** And whether or not there is an intrusion there,

right?

A. Yes.

Q. And how did you score this?

A. I believe that that was a perseveration on the Number 3.

Q. I'm sorry?

A. I thought what was a perseveration.

Q. You are going to have to explain what that is.

A. That is that he simply kept repeating himself, so he drew ABC, 123, and then drew a 3 again.

Q. But if that's this little -- the -- the -- let's go the other way. If that little mark down here, if -- here?

A. Yes.

Q. If that's an intrusion, then he's got a negative one?

A. It is not an intrusion in my opinion.

Q. I am asking if it is. If it is.

A. Yes.

Q. If not, he has got zero; if it is, it is a negative one?

A. Yes.

Q. But in your judgment, that is what I am asking you about really, is your judgment, you count that as a three?

A. Yes. Yes. Actually, when you enlarge like that it even looks more like a three. Yes.

Q. Okay. But if it is not, it is still a zero, right?

A. Yes, it is. Right. Yes.

Q. And so how did you score this test for Mr. Brockman?

A. So -- you're right. So, the new combination score is a zero which is found in 6.8 percent of the sample. If you see here, see the zero, the cumulative percent, 6.8 percent, and then you see actually where you're showing here the pattern analysis of scores.

So when I calculated his performance on a pattern analysis, which requires three different things to happen; recall less than three, true positives less than three, false positives greater than five, Mr. Brockman met none of those criteria.

So according to the pattern analysis, that is explained in the column that's beneath what I can see here, in fact, you can see some of them, again, that is what the authors call actually a more accurate way of looking at a disingenuous performance than compared to the -- to the combination score.

Q. But you scored this as a pass?

A. I scored it both -- yes. Yes.

Q. And accord ing to Fazio, that means that Mr. Brockman is in the 3.9 percent, right?

A. No, 6.8 percent.

Q. I'm sorry. 6 -- zero, right, less than zero, 6.8. 3.9 if it was in -- if that little mark is an intrusion,

but it's 6.8?

A. Yes.

Q. All right. So you, in your judgment, put him in the 6.8 as opposed to the 93.2, right?

06:24:22 You put him in the pot that -- in that smaller pot?

You are saying, he actually wasn't malingering. He's in that little tiny population of truly demented people at little 6.8?

06:24:33 **A.** I am saying that that was the -- that a score of zero appears or occurs -- a score of zero or less occurs in 6.8 percent of the sample and, as I had also mentioned, the profile analysis is completely normal with regard to identifying a disingenuous performance.

06:24:51 And the authors make the claim that the profile analysis is a stronger marker of -- of invalidity than their combination scorings.

Q. What goes into the profile analysis?

A. As I had mentioned, so there are -- there are -- 06:25:06 there are three things; one is, does the patient score -- does the patient generate less than three on recall? That's one.

Another one is -- and then, and -- are there -- does the person make fewer than three true 06:25:21 positive responses on recognition, or make more than five

false positive errors on recognition?

If you have a failure on the first item, that is the recall less than three, then if you then have a fail on the other two, then that -- that profile was obtained by zero percent of their sample.

And Mr. Brockman never gets -- Mr. Brockman passes the -- their profile analysis.

Q. But on the combined score, you as a test scorer, you're putting him in the 6.8 percent people that score in that range as being truly demented. That is a judgment you're making, right?

A. I am making a judgment that that is -- that that was his score based upon their combination profile.

Q. Right. Let's go to the Coin-in-the-Hand Test, which, again, I have your score sheet from October 2nd that I am going to mark as 167.

And you have already described this on direct, so we won't go through it again. This is when you put the coin in the hand and get him to guess what coin.

He actually made three errors; is that right?

A. Yes.

Q. And two is normally a fail, right?

A. No. Three is a fail.

Q. So he failed this test?

A. Yes.

Q. But you didn't score it that way, you scored it as a pass?

A. No, I think I scored it as a fail.

06:26:55 **Q.** So he did fail this test?

A. Yes.

Q. Oh, okay. Then we can move on. So he did fail one validity test in October?

A. He -- although -- although --

06:27:04 **Q.** Two, we got two now, the MSVT and the Coin in the Hand?

A. Although, again, however, I would say that other data indicates that -- that the -- that the cutoff score of seven or more -- of seven or fewer correct, will result in

06:27:20 a significant number of false positive errors.

Q. I am not going to get into that, but you scored it as a fail?

A. I did.

Q. Okay. And then he failed the MSVT. We just went

06:27:34 through that calculation, right?

A. Yes.

Q. Okay. One last test I want to ask you about which you discuss on page 18 of your -- the CPT 3 test.

How did you score this test for

06:28:03 Mr. Brockman?

A. How did I score it?

Q. Yes.

A. Well, it is computer scored.

Q. So how did it score?

06:28:08 **A.** It showed that he made a significant number of especially omission errors.

Q. Which I am marking for identification as 168. This is the report that came out?

A. Yes.

06:28:21 **Q.** So, go ahead. What does that mean?

A. That when the target stimuli was shown, he -- he failed to respond to it.

Q. And what does that mean?

A. That means he was very inattentive.

06:28:37 **Q.** If the error -- isn't it a consensus in the field that if the error rate exceeds 25 percent, that that's a fail?

A. No.

Q. Let me just ask you a couple questions about this.

06:28:55 Are these bars where I am pointing, those are at the fail rate, right?

A. Well, this is not the sort of test that has a pass/fail.

Q. I'm sorry. Not the fail rate. The error rate. The

06:29:09 errors that he made, right, he made a large number of

errors?

A. Yes.

Q. Is that what is depicted on the graph?

A. Well, it depends. Those actually are described as T scores. They are not all errors. Some have to do with reaction time. Some have to do with variability of his reaction time.

So it's not just -- all those -- all those things that you see on the left-hand side are -- some of those reflect errors, some of them have nothing to do with errors.

Q. So, again, how is he scored on this? How did the computer score him on this with all these errors?

A. I'm not sure -- so, you -- you see that -- his T scores, his --

Q. Right.

A. -- his performance on many of these -- many of these fall outside the normal limits.

Q. Okay. And that is a fail?

A. There is no failure.

Q. Okay.

A. That is not how it is scored.

Q. So how is it scored?

A. It's a -- it's a performance relative to the normative group.

Q. And how did Mr. Brockman do against the normative group?

A. Mr. Brockman made many more errors, was much slower than -- than others in his age group.

06:30:24 **Q.** And so that he fell out of the valid range?

A. He fell outside of the normal range.

Q. Yeah.

A. Or the average range.

Q. Yeah. So -- and this is a validity test, right?

06:30:34 **A.** No.

Q. It is not a validity test?

A. It's -- no.

Q. But he fell outside the normal range?

A. Yes.

06:30:39 **Q.** Okay. So let's summarize now. So we had validity tests that you administered in May -- I'm sorry, July. Validity tests you administered in October. How many -- we know he failed two?

A. I still actually -- you know, what I --

06:30:56 **Q.** In October --

A. Pardon me. I am -- you know, I would need to spend more time with the MSVT data.

Q. Well, we did the math.

A. We did the math.

06:31:05 **Q.** We followed the instruction sheet and it comes out as

a fail?

A. But, still, but the -- the AI profile created or generated a possible memory -- a possible genuine memory impairment.

06:31:20 **Q.** Right. And when you have a genuine memory impairment, you do the math in step two to see if it is a real memory impairment or if it is implausible profile. We did the math right here live, and it came out following the instructions in the test that it was a fail.

06:31:35 So let's move on.

I want to ask how many tests did Mr. Brockman fail for you in the July exam? Validity tests. How many validity tests did he fail --

A. I --

06:31:48 **Q.** -- in July.

A. In July?

Q. Two, right? Two?

A. The -- perhaps the MSVT and Coin-in-the-Hand Test.

Q. And then in October how many did he fail?

06:32:04 **A.** I'm sorry. That was -- I thought you were referring to October.

Q. So October was two. How many in July the first time?

A. In July? I don't know that he failed any. Did he fail? No.

06:32:23 I mean the A-Test, he initially failed;

but I thought that was -- that that was truly a -- a false positive fail.

Q. What does that mean, a false positive?

A. Meaning that he failed it, but not because he was -- 06:32:37 not because of inadequate effort. He failed it because he became too confused.

Q. Right. Right. And that is your judgment, that he became too confused?

A. Yes.

06:32:44 **Q.** That is your interpretation of what you saw?

A. Yes.

Q. Okay. So are you familiar with the -- well, we have talked about it, the article, The Clinical Neuropsychologist, and the consensus in the field, in your 06:33:00 field, that two or more failed validity tests indicates that the -- it's a fail, and that the cognitive testing is unreliable? Isn't that -- I think you already said that.

A. Yes.

Q. Okay.

06:33:11 **A.** Except in cases of dementia, or of severe brain injury, or severe psychotic illness.

Q. And actually the consensus opinion of the American Academy of Clinical Neuropsychologists, which we have now marked for identification as 162, says it is even possible 06:33:30 that one failed test could indicate unreliable testing?

A. Oh, no, I -- well, I mean the -- upwards of 40 percent of -- of individuals who have no incentive to fake bad, or whose testing is completely valid will -- will fail one validity test.

06:33:53 **Q.** But that's the key, isn't it? That's -- do they have a motivation to fail? Do they a motivation to malinger? Isn't that what this is about?

A. Well --

Q. Let me show you 162 again. This is the American

06:34:12 Academy of Neuropsycholgists Consensus Report from 2021, marked as 162.

"However, a single invalid PVT performance within a large test battery can indicate a transient validity problem."

06:34:29 **A.** Yes. Yes. However, also in that document is a statement that with increasing deficits, especially in dementia, severe head injury with loss of consciousness, significant psychiatric illness, that there is the expectation that patients will fail more PVTs, or their

06:34:51 performance will be less well on PVTs, not because of invalidity issues but rather because of a genuine memory deficit.

Q. Right. So that is what I am asking you about Dr. Guilmette, that presupposes that the patient actually

06:35:06 has dementia?

A. Yes.

Q. So you are presupposing that he has got dementia, you are testing him for dementia, so you are making a judgment about the patient in order to interpret the test?

06:35:19 **A.** I made a judgment first about the dementia and then considered his performance on the validity test.

Q. Exactly. Exactly. And that is what I am asking you about. You already determined that he had dementia before you tested him, isn't that right?

06:35:31 **A.** No. No. No. No. No. At the time I take -- when I saw him, that is when -- after I saw him, is when I made the determination of dementia. I didn't go into the evaluation presuming that he was demented.

Q. All right. Let me show you another part of the

06:35:50 American consensus on neuropsychology, another page, it's page 1067.

A determination of malingering may be appropriate even when all PVT, validity tests, are passed, depending on the entire test data. Right?

06:36:08 **A.** Yes. Uh-huh.

Q. So, you have to look at the whole picture, but this is what I am asking you about: In your judgment, you're scoring the test as if Mr. Brockman already has -- you have already determined he has got dementia?

06:36:22 **A.** When you say "already," at what -- at what time frame

are you --

Q. When you're testing. When you're testing him.

A. At some point you make a diagnosis. At some point you make a determination.

06:36:32 **Q.** Okay. Well, that's what I am asking you.

A. So what's the question?

Q. The question is: Isn't it true that when you're testing him in October and in July, you're already testing him, making a determination that he has dementia, which

06:36:51 influences how you score the test? Like giving him a second chance? Where you put him on the statistical curve? He is in the population of demented patients that take -- you compare him against other demented patients, isn't that what you're doing?

06:37:06 **A.** After I made the determination that I thought he had dementia.

Q. That's right. That's what I am asking you. Okay.

Now, the other thing -- oh, yeah. Before I move on from the testing. One more article I want to

06:37:23 show you, the American Academy of Clinical Neuropsychology Consensus Conference in 2009. You were a member of that conference, weren't you?

A. Yes.

Q. You weren't a member of the 2021, but you were a

06:37:36 member in 2009?

A. Yes.

Q. Are you aware that Dr. Denney was a member of the consensus conference in 2021?

A. No.

06:37:42 **Q.** He was. He testified to that Monday, Tuesday, last week. Were you aware of that?

A. No.

Q. Okay. So, you drafted a part of this consensus conference. Right?

06:37:57 **A.** Yes.

Q. The section on "Ability"?

A. Yes.

Q. And didn't you say --

MR. SMITH: Well, I guess I have to mark this.

06:38:03 That's right. I am going to mark this as 169.

MR. LOONAM: Is that your only copy?

MR. SMITH: No. No. I am getting it for you.

MR. LOONAM: Thanks.

MR. SMITH: Here you go.

06:38:28 MR. LOONAM: Thank you, sir.

BY MR. SMITH:

Q. I just want to ask you about some sections that you wrote in what I am showing you, 169. Do you want a copy?

A. I don't have a copy. If I can see it here, that

06:38:42 would be fine.

Q. Yeah. Yeah. I'll see if I can get this on the screen.

MR. LOONAM: Which page are you going to?

MR. SMITH: Yeah. Give me a second. 1100.

06:38:52 MR. LOONAM: Thanks.

BY MR. SMITH:

Q. Do you want to take a second and get to that page, Dr. Guilmette?

Actually, I want to go to 1101 first,

06:39:20 Page 1101. I will put it on the screen. Can you see that?

A. Yes.

Q. So, this is a part of the 2009 consensus statement for neuropsychologists that you wrote or that you

06:39:34 co-authored; is that right?

A. Yes.

Q. And did you say here that, in order to determine malingering or less than full performance for secondary gain, you have to look at scores that are below chance --

06:39:53 Well, let me rephrase the question.

Initially, what you're commenting on is the way your field was initially doing this was it had to be -- the scores had to be significantly below chance to be malingering?

06:40:06 **A.** Yes.

Q. And then you write this part of the article that says, 'Well, that's wrong. It can be just slightly below chance.'

A. I don't see where it says that.

06:40:18 **Q.** "Additional research is now well known that invalid performance can be identified using thresholds that are well below" -- "above a level that is significantly below chance."

A. Yes.

06:40:31 **Q.** Isn't that what that says?

A. Yes.

Q. So, the old thinking was it has to be significantly below chance to be malingering, to be invalid, but what you were saying in '09 with your coauthors is that, no, it

06:40:42 could be above significantly below, something -- a larger number?

A. It simply -- however, it's not talking about malingering. It's simply talking about invalidity, number one.

06:40:51 **Q.** Uh-huh.

A. And, number two, this does not address the issue of testing older adults or significantly older adults with dementia.

Q. Okay. Okay. But -- so, there is -- there is dispute

06:41:05 in your field about how to score some of these tests and

where to put the score and how to interpret it, depending on where they fall in the statistical curve. Right?

A. Not to call it something significantly below chance. "Significantly below chance" still remains a concept that has not been -- for which there is still not consensus. This is simply talking about a cutoff for invalidity, which is different from a significantly-below-chance performance.

Q. But invalidity -- that's what we have been talking about all evening, invalid validity tests. Right? If you get an invalid score, it means you're trying to fail the test?

A. Not necessarily. An invalid score can occur because of fatigue, because of genuine memory deficits. I'm trying to make the distinction between invalidity versus malingering.

Q. Right. No. I didn't mean to say malingering. I'm not in your field. I misspoke. I meant invalidity.

You are saying here that to determine invalidity it doesn't have to be all the way at the end of the curve; it can be something a little bit higher?

A. Oh, sure.

Q. That's what you are saying here?

A. Yes.

Q. And that's the difference, is it not, between you and

Dr. Denney? Dr. Denney scored it but statistically a little bit different than you did. You went to the far end of the curve for Mr. Brockman. And when you had to exercise your judgment, you presupposed he had dementia. So, you always pushed him in the bottom end, and you counted the score as valid because he had dementia, in your opinion?

A. No. So, Dr. Denney took a score that was not -- that he claimed was significantly below chance as an indicator of malingering. So, he said -- the smoking gun of intent, as he described.

Q. Right.

A. Right? Okay. So, there is -- there is -- his decision to say that -- that a P value of .075, that's statistically below chance is his opinion.

There is -- my point is that there is no consensus on what should basically be below chance, when you're talking about a fact of malingering versus testing validity.

Q. Right. And we already went over that and we are not going to go over it again. But what I'm asking you: Isn't that essentially what you're saying in your own article in '09, that this is a fluid analysis, and that only looking at scores as invalid that are significantly below chance is something that you shouldn't do? Isn't

that what you're saying?

A. No. No. I am not saying that.

Q. All right. Let's move on to another page of your article or your section of the consensus opinion. I want to move and switch gears to what you say on Page 1100, and I have got it on the screen.

Do you see that?

A. Yes. I see three highlighted areas.

Q. All right. I want to direct your attention to where it says, "Real world behavior can be essential in addressing the possibility of malingering."

A. Okay.

Q. What does that mean?

A. That means does the person exhibit evidence of impairment in their everyday life?

Q. And if they don't -- Well, let me ask it this way.

So, real world behavior, what do you mean by that?

A. Oh, that can mean being able to take care of one's self, pay your bills, drive, function in society.

Q. Could it include things like giving depositions, giving speeches, looking at their behavior at the workplace?

A. It could.

Q. So, those are real world behaviors, right --

A. Yes.

Q. -- that, according to you, Dr. Guilmette, are essential in determining if someone is malingering?

A. It's part of it.

06:45:08 **Q.** Well, that's what you said in the article in 2009. Right?

A. Well, I didn't -- you know, this was an article written by 20 people. So, I didn't necessarily write that particular line. But I agree that review of everyday

06:45:24 behavior is an important component in assessing malingering.

Q. So -- and you have to compare the real world behavior. And we know in this case, in 2019, Mr. Brockman gave a deposition, in January of 2019. He gave a

06:45:43 deposition in September 2019. He gave speeches in November of 2018 and December of 2019 in which -- and, according to the testimony and the depositions, he performed really well.

A. Uh-huh.

06:45:58 **Q.** Are you aware of that?

A. Yes.

Q. Now, in 2019 he was also examined by Dr. York twice. Right?

A. Yes.

06:46:05 **Q.** And you have reviewed those records?

A. Yes.

Q. Did Dr. York make any comment on -- Before I talk about Dr. York, in your field what you call that is collateral contrary evidence -- contradictory evidence. Right? Are you familiar with that term?

A. Con --

Q. Contradictory evidence.

A. Okay.

Q. Collateral contradictory evidence.

A. Well, I am not familiar with that phrase specifically, but --

Q. All right. All right. So, let's just talk about what Dr. York did in 2019.

So, you reviewed Dr. York's reports of her testing of Mr. Brockman in 2019. Right?

A. Yes.

Q. In March and then in December?

A. Yes.

Q. When you reviewed those reports, did she mention anything about the deposition? Let's just start with March.

In her March report, which was six weeks after he gave a deposition on January 16th, did she comment on that deposition?

A. Not that I remember.

Q. Did she analyze it compared to her testing?

A. No.

Q. Did she talk about at all in her report about the motive to fabricate or exaggerate symptoms by Mr. Brockman?

A. No.

Q. Did she talk about the secondary gain, the motive for secondary gain?

A. No.

Q. Did she talk about a timeline of the fact that Mr. Brockman -- there was this search warrant -- and I am going to get to that more in a minute -- but there was a search warrant on September 5th of 2018?

A. Yes.

Q. And that there was a timeline of this criminal investigation, and that by March of 2019 he knew about the criminal investigation. Right?

A. I -- I am not exactly sure when he became aware of the investigation. Oh, by 2019, did he --

Q. Yeah.

A. Yes. Yes.

Q. Don't you say in your report --

A. Yes.

Q. -- that you were told he became aware of the criminal investigation in September 2018?

A. Okay.

Q. So, by March of 2019, when Dr. York is evaluating him, he already knows about the criminal investigation?

A. Yes.

06:48:10 **Q.** Did she comment on that?

A. No.

Q. So, in March of 2019, she did not comment on the motivation to fabricate to avoid criminal prosecution, the fact that he didn't report any symptoms to any doctors

06:48:26 till after September, the timeline, and the motivation -- the motivation to fabricate or the -- or the deposition he had just given six weeks ago?

MR. LOONAM: Your Honor, that's a really long question.

06:48:39 MR. SMITH: I can -- I'll break it up. I'll break it up.

THE COURT: You can break it up. I mean, just one at a time. Did she comment on this? Did she comment on that?

06:48:46 BY MR. SMITH:

Q. Did she comment on the deposition in January 2019?

A. No.

Q. Did she comment on the motivation to get -- for secondary gain to avoid prosecution?

06:48:56 **A.** No.

Q. Did she comment on the timeline of knowing about the criminal investigation?
A. No.
Q. What about in December? Are you aware of the fact that there was another deposition in September of 2019 with the Federal Trade Commission?
A. Yes.
Q. And you reviewed Dr. York's report in December 3rd of 2019 --
A. Yes.
Q. -- two months after that deposition? In her report, did she comment on that deposition just six weeks earlier?
A. No.
Q. Did she comment on the motivation to fabricate or avoid secondary gain in the criminal case?
A. No.
Q. Did she even comment on the criminal case?
A. No.
Q. So, according to Dr. Guilmette, she ignored real world evidence?
A. She was unaware of it, apparently.
Q. Okay. Doesn't that impact her ability to test Mr. Brockman's cognitive ability if she is unaware of real world evidence?
A. Well, she did receive some evidence or some report

from Mrs. Brockman and also their son.

Q. But apparently not the deposition --

A. Correct.

Q. -- no comment about the criminal case and what motivations it may instill in Mr. Brockman. Right?

A. Correct.

Q. And Dr. Guilmette says that that's essential; is that right?

A. Ultimately, that is an important part of the evaluation.

Q. What about the October 7th?

A. October 7th --

Q. Dr. York, her evaluation of Mr. Brockman on October 7th.

A. In 2020?

Q. Yes.

A. What about it?

Q. Well, did you review it?

A. Yes.

Q. Okay. And in that examination she also ignored the criminal case, the depositions, didn't she?

A. Yes.

Q. She also ignored the fact that he was still running Reynolds and Reynolds, didn't she?

A. I don't recall exactly what she commented on

regarding his work situation.

Q. Well, you reviewed her report. I can give it to you if you want to look at it. Did she comment on the fact that he was still -- in October of 20 -- October 7th, 2020, Mr. Brockman was still running Reynolds and Reynolds?

A. It -- I'm sorry. Is that what she said or --

Q. I am asking you if she commented in her medical report that on October 7 of 2020 Mr. Brockman was still running Reynolds and Reynolds?

A. I don't recall.

MR. SMITH: What is the -- I believe this is Defense Exhibit 35.

MR. LOONAM: Which one is this?

MR. SMITH: Defense Exhibit 35. This is the October 7th medical report by Dr. York.

MR. LOONAM: York?

MR. SMITH: Yeah.

BY MR. SMITH:

Q. I'm just going to show you where she does her conclusions, Dr. Guilmette.

A. Okay.

Q. Well, first of all, what she says is that he has got dementia with mild to moderate severity, right here. Right?

A. Yes.
Q. And is there any comment in there at all or any analysis or reference to the fact that he's still running a multi-billion-dollar software company on October 7th of 2020?
06:52:51
A. There is no mention of that.
Q. Okay. So, Dr. York examines Mr. Brockman in January of 2019 -- I'm sorry -- March 2019, in December 2019 and, again, in October 7th of 2020?
06:53:25
A. Yes.
Q. And she doesn't refer to any things that are happening outside of the examination room, that Mr. Brockman is involved in the depositions, the running of the company, e-mails that he is sending to underlings
06:53:35
in Reynolds, none of that is in her reports?
A. Correct.
Q. But you still reference her report in your reports; isn't that true?
A. Yes.
06:53:42
Q. And what I want to ask you about here is this REM behavior disorder here --
A. Yes.
Q. -- that she references. She actually references that in all three of her reports. Right?
06:53:53
A. Yes. I think so.

Q. And you rely on that. Right?

A. I don't believe that he has a REM behavior disorder.

Q. Right. Right. But there was a sleep study done in August where the sleep study -- the doctor conducting the sleep study determined he did not have REM disorder. Right?

A. Was that the one that there was not enough sleep time? Because he has had two sleep studies.

Q. Right.

A. I know the first one -- and I don't recall the dates -- the first one revealed that there was not enough REM behavior, there was not enough REM sleep to make that diagnosis.

Q. Yeah. Let me show you the one in August, as soon as I get the exhibit number.

MR. SMITH: Do you remember what number this is?

MR. LANGSTON: It's like 42, Corey.

MR. SMITH: 42. Thank you. So, this is Government's Exhibit 42.

MR. LANGSTON: It should be in evidence.

MR. SMITH: Yeah, this is already in evidence.

BY MR. SMITH:

Q. This is the sleep study in August. Did you review these?

A. Yes.

Q. I'm just going to draw you right to the conclusion, and I am almost done. I know it's getting late.

412 minutes of sleep, the duration of the sleep, normal REM latency. Do you see that?

A. Hold on a second. Can you put that --

Q. I'm sorry.

A. The duration of REM sleep was 47 minutes. Okay. Normal REM latency. Okay. Uh-huh.

Q. Page 2. There was no loss of normal --

MR. LOONAM: Is that 42? I'm sorry.

MR. SMITH: Yes, it's 42.

MR. LANGSTON: It is the August sleep study.

BY MR. SMITH:

Q. And you have already testified that you don't think he had REM disorder?

A. Correct.

Q. Just -- you weren't sure which one it was, so I'm just showing this. Does this refresh your memory?

A. Yes.

Q. Okay. Yeah. But after this test was done, in your October report you're still relying on Dr. York's findings, aren't you?

A. I am relying -- I'm sorry. Say that again. When?

Q. In your October report that was submitted -- October

29th in this hearing, you're still relying on Dr. York's report even though this sleep study contradicts her findings?

A. It contradicts -- it doesn't contradict her neuropsychological findings. It simply contradicts what she thought was going on with Mr. Brockman with regard to his sleep. And by my last report, I was relying mostly on my findings and his more recent history.

Q. I'm sorry. I misspoke. You're correct. Her diagnosis of Lewy body dementia. Isn't that what she says?

A. Yes.

Q. In each of her reports?

A. Yes.

Q. And then we get the sleep study which says he doesn't have REM disorder, which is a hallmark of Lewy body disease. Right?

A. It's an important feature.

Q. So, that comes out in August. Your report comes out in October. But you still cite Dr. York's report in your report; isn't that right?

A. Yes. But I don't agree with her -- with her final diagnosis.

Q. Right. You still cite her report?

A. Yes.

Q. And you use it as -- you use it as support for your conclusion that she -- that Dr. Brockman -- Mr. Brockman has dementia, because of her testing?

A. Sorry?

06:57:34 **Q.** Because of her testing.

A. If there were no such person as Dr. York, I would have still -- and that testing, based upon the data that I saw from Mr. Brockman, especially in -- in 2021, this year especially, in addition to the neuroimaging findings,

06:57:51 other information --

Q. Uh-huh.

A. -- his performance on testing, I would make the same diagnosis regardless of what Dr. York said.

Q. So -- I understand that. So, we can put Dr. York

06:58:01 aside. Her diagnosis is wrong.

A. Her diagnosis is incorrect.

Q. And she didn't consider real world evidence that was occurring contemporaneous with her evaluations of Mr. Brockman. Right?

06:58:11 **A.** Yes.

Q. Okay. So, let me ask about your report.

In your report, both of them, you also don't consider real world evidence, do you? Let me rephrase that. I'm sorry. You consider some real world

06:58:25 evidence. You don't consider contradictory real world

evidence?

A. For example?

Q. For example, the deposition in 2019 -- in January 2019. For example, the deposition September 2019, the 06:58:39 speech in November 2019 that Mr. Brockman gave to his assembled employees in 2018. All of this activity which is contradictory to a finding of mild or moderate dementia, it's not referenced in your report, is it?

A. It was two years before that time. His -- his 06:58:56 functioning in 2021 was very different from the years before that.

Q. So, do you think he had dementia in 2019?

A. I believe he had the -- the early signs of dementia.

Q. And you -- but you don't talk about that in your -- 06:59:12 Well, let me rephrase that question.

In your report, you don't consider or you don't comment -- I should say you don't comment on these depositions and this other activity in 2019 as impacting your evaluation?

06:59:26 **A.** Correct.

Q. Okay. So, I just have a few more questions I want to ask about your reports.

Your first report, which is Exhibit 19, Defense Exhibit 19, I think you have there -- I ask you to 06:59:51 turn to Page 72.

A. I'm sorry. This is the first one?

Q. Yeah, the first one. Yes. Page 72.

A. Page 72. Okay.

Q. So, you're -- you're talking about -- this is Question 6 counsel asked you about --

A. Yes.

Q. -- is he malingering? And you have that first bullet point there. Do you see that?

A. Yes.

Q. One example was that "The diagnosis of malingering is being asserted" -- Well, let me just ask you a question.

You dismissed the malingering or the accusation of malingering in that first bullet point because you believe that Mr. Brockman did not learn of the criminal investigation until September 2018. Isn't that what that says?

A. So, my impression was -- from Dr. Dietz's report was that Mr. Brockman began to malinger cognitive impairments after the raid of Mr. Tamine's home in Bermuda.

Q. And see where it says "However"?

A. Yes.

Q. "However, evidence of the decline in Mr. Brockman's functioning observed by those around him predates the raid in 2018."

A. Yes.

Q. So, isn't that presupposing that Mr. Brockman didn't know about the criminal investigation in 2018?

MR. LOONAM: Argumentative, asked and answered. He said he --

07:01:49 THE COURT: Objection overruled.

BY MR. SMITH:

Q. Doesn't that presuppose that Mr. Brockman did not know about the criminal case until 2018?

A. Not necessarily.

07:01:56 **Q.** So, when do you think Mr. Brockman learned about the criminal case?

A. I -- from what I understand, he -- the -- the point that I was trying to make, which is my impression of Dr. Dietz's report, was that Dr. Dietz indicated that the

07:02:19 malingering of impairments began following the raid on Evatt Tamine's home.

Q. And that was part of the criminal case?

A. Yes.

Q. So, you are saying, well, that's not valid because he

07:02:31 had -- what you're saying in that bullet point is that Mr. Brockman had evidence of or reported evidence of cognitive problems before the raid on Mr. Tamine. Isn't that what you're saying?

A. Yes.

07:02:43 **Q.** So, wouldn't that imply that Mr. Brockman -- to

dismiss what Dr. Dietz says, you're implying that Mr. Brockman didn't know about the criminal case before the raid on Mr. Tamine's home?

A. My understanding is that he -- that he was aware of some investigation at some point before that.

Q. So, what's your understanding?

A. I don't --

Q. So -- well, what is your understanding of when Mr. Brockman learned of the criminal case?

A. Sometime before -- sometime before the raid on Mr. Tamine's home.

Q. And why is that important? Isn't it -- Well, let me ask it this way.

Dr. Guilmette, isn't part of this analysis that you have done in your report here is that -- the conclusions you want the reader to draw is that Mr. Brockman is not malingering because -- he's not malingering because he didn't -- he was reporting symptoms earlier than the criminal case; therefore, his symptoms are not coming -- the impetus is not the criminal case?

A. He was reporting cognitive symptoms as far back as 2004.

Q. Okay. Okay. Let's look at the -- let's look at the other report, the October report. Defense Exhibit 22, Page 39. And I am going to put it up on the screen.

Actually -- I'm sorry -- it's Page 40.

Do you see that, Dr. Guilmette?

A. Yes.

Q. And this is sort of the conclusory part of your report in October?

A. Yes.

Q. So -- and you say, if I can point my pen to it: "Across Mr. Brockman's many neuropsychological evaluations, 23 PVTs, the validity tests, were administered, and of these 17 scored in the valid range?

A. Yes.

Q. Which means he failed six validity tests. Right?

A. Yes.

Q. And we have already looked at the literature from the American Academy of Neuropsychologist's consensus. A "2" indicates invalid scores?

A. Not in cases of dementia, also not in cases especially with the Green test in which a Genuine Memory Impairment Profile is produced. Those are not -- Yes, his scores fell below the cutoff. That doesn't mean that he actually failed the test.

Q. That's because, in your -- in your -- Well, he failed six tests. Right? That's what you say in your report?

A. Yeah, that he -- he received failing marks, so to speak. He fell below the cutoff for those tests but that,

again, he generated a Genuine Memory Impairment Profile.

Q. On some -- on some of the tests?

A. On all of them.

Q. Well, some of that is your interpretation, is it not? I mean, we just went through one, the GGVMT. Is that the right way to say it?

A. I don't know.

Q. The Green -- the one that we did the calculation. That was not a Genuine Memory Impairment Profile?

A. Well, again, however, I would rely on the advanced interpretation -- interpretation of that.

Q. So, is there any way, in your assessment, Dr. Guilmette, that Mr. Brockman could fail a validity test?

A. Yes.

Q. It doesn't seem so.

A. It is possible. The -- the scores that he -- On the Rey 15-Item Test, again, the -- the marker of invalidity that -- that he passed three times out of three times, he never failed that. The other measures, in which he -- he performed within the acceptable limits, yeah, it -- he certainly could have failed.

Q. But, in your opinion, he did not?

A. My opinion is he -- he failed the ones that I mentioned in my report and passed the ones that he

mentioned -- that I mentioned in my report.

Q. But even though he failed some validity tests, you are still saying your opinion is the cognitive testing is correct and that Mr. Brockman, when you test him, has moderate to severe -- was it moderate to severe -- or mild to moderate dementia?

A. Yes.

Q. And a lot of that test interpretation is your judgment?

A. Yes.

Q. Okay.

MR. SMITH: No further questions.

THE COURT: We are going to have to cut it off for the evening.

MR. LOONAM: I have --

THE COURT: Do you have --

MR. LOONAM: I will do a quick redirect so that this witness can get on a plane tomorrow morning --

THE COURT: Okay.

MR. LOONAM: -- if that's okay with Your Honor. I'll be short.

THE COURT: Sure. That will be great. We can't stay past 7:30.

MR. LOONAM: Oh. No. No. I will -- I will limit myself. Self control, Your Honor.

THE COURT: Okay. Well, I am not -- I'm just telling you sort of the outer bounds, because, as I said, we have got issues with power and other things that there is nothing I can do about it.

07:08:29 MR. LOONAM: All right.

REDIRECT EXAMINATION

BY MR. LOONAM:

Q. There was testimony about two being sort of the cutoff for failed validity tests.

07:08:41 How many validity tests are typically administered in a course of testing?

A. In a forensic evaluation?

Q. Yes.

A. Oh, six-ish.

07:08:51 **Q.** Six or seven?

A. Yes.

Q. So, if you do six or seven and if you fail two, the cutoff is -- well, that's a -- that's an indication of exaggeration?

07:09:00 **A.** Yes.

Q. Does it -- does it matter if -- You know, how many validity tests did Mr. Brockman take?

A. I think 23 is what was -- the number that I calculated.

07:09:12 **Q.** Yeah. And, so, might that impact, you know, the

number of tests that -- that he could fail and -- Speak to that.

A. Yes. So, there is -- there is certainly thinking in the field that the more PVTs you give, the more likely you are to find false positives. If the accepted range, generally speaking, is two out of seven failures, then that means four out of 14, six out of 21 failures, would more likely denote an invalid profile.

Q. Okay. You were questioned about -- about referencing Dr. York in your report. Did Dr. Denney reference Dr. York in his report?

A. Yes.

Q. Now, there was discussion of the timeline and -- in 2018 and -- and you testified that, well, in Dr. Dietz's report he put the sort of demarcation line at a search in Bermuda and that, in Dr. Dietz's report, he suggested that Mr. Brockman began malingering after that search in Bermuda. Correct?

A. That was my impression, yes.

Q. And you testified that -- Oh, yes. I am going to show you what is in evidence as Government's Exhibit 153. These are health notes that were provided by a Dr. Lisse.

A. Yes.

Q. Do you know who Dr. Lisse is?

A. Yes.

Q. Okay. So, these notes are from 2015, and they indicate, "Unfortunately, for most of the year I felt like something" -- "I felt like sometimes 40 percent of my energy was gone. Something is really wrong with me." And then under "Mental Processes Including Memory" -- this is on Page 4 of 9 of the document -- "Mental processes not as good but no further serious decline. Memory continues to get poorer, especially with names of people that I know well and should be remembered easily. In a new weird phenomena, names that I ought to remember, like one of our maids and a restaurant close by the house that I have been to 20 times or more, yet have had real problems remembering these two names. Ability to work long hours effectively is now pretty much as good as ever now."

All right. Did you review notes like this?

A. Yes.

Q. Yes?

A. Yes, dating back to 2004.

Q. And sometimes these notes repeat themselves?

A. Yes.

Q. And the fact that this was found in Dr. Lisse's files from 2015, does that give you another piece of data with respect to evaluating whether Mr. Brockman is malingering?

A. Yes. This -- this certainly suggests that he had

subjective cognitive complaints, well, in 2015.

Q. And what might that process be that he is observing?

A. He might be experiencing the very early signs of a cognitive decline associated with dementia.

07:12:18 **Q.** Okay. And I am going to ask you about the last line here, "Ability to work long hours effectively is now pretty much as good as ever now." What does that tell you about whether this document is being created as some sort of grand conspiracy to leave a paper trail to malinger

07:12:34 years down the line in case a need arises?

A. Yeah. Well, so, that -- that would certainly suggest that there was no attempt there to make himself look worse than he actually was.

THE COURT: Counsel, I don't mean to interrupt,

07:12:48 but just a quick question. How long was Mr. Brockman seen by Dr. Lisse? Was there testimony -- I know at least 2015, but how long was he Mr. Brockman's PCP?

MR. LOONAM: I'd have to go back and look at the testimony.

07:13:04 MR. BOURGET: I think the testimony is from 2015 to 2018.

THE COURT: And who was before that?

MR. LOONAM: Obenour.

THE COURT: Obenour?

07:13:14 MR. LOONAM: Dr. Obenour.

THE COURT: And do we have any records from him?

MR. LOONAM: I think -- are those the records we turned over? We got those records when Dr. Obenour retired.

07:13:24

MR. MAGNANI: I don't think that is right. So, yeah, my understanding of it, Your Honor, is that when Dr. Ryan Darby, who was the first witness who testified, when Mr. Brockman brought up that he had medical records in his house, he told Dr. Darby, I had this doctor, Dr. Obenour, and when he retired he didn't want to digitize his records. So I persuaded him.

07:13:36

Basically the representation of Mr. Brockman is that the box of records that Jones Day produced to us after the Darby interview are the Obenour records.

07:13:49

MR. LOONAM: No. We're on the same page. We are in agreement. So that is our understanding, too, that Mr. Brockman had these records from Dr. Obenour. When we learned of them, we turned them over.

07:14:01

THE COURT: Yeah.

MR. LOONAM: But, yeah, these records were in Mr. Brockman's possession, if that's the government's point.

MR. MAGNANI: Nobody got any records from

07:14:08

Dr. Obenour.

MR. LOONAM: He was long retired.

THE COURT: I just wanted to kind of figure out the sequence of events of when Mr. Brockman changed PCPs. It was Dr. Obenour in 2015. It was Dr. Lisse. And then basically, September, or 2018 he switches --

MR. LOONAM: To Pool.

THE COURT: -- to the doctor we heard today.

MR. LOONAM: That is correct. So this would be contemporaneous when he changes doctors to Dr. Lisse.

THE COURT: Okay. Got it. I didn't mean to interrupt. I just wanted to make sure I understand the sequence.

MR. LOONAM: Not at all, sir.

BY MR. LOONAM:

Q. And there was -- there seemed to be a lot of questions about, Well, if you scored the test that way, you presupposed that the defendant had dementia, or -- and so the questions flowing from that thinking. Do you recall those questions?

A. Yes.

Q. Are you aware that the government's own experts, Dr. Dietz and Dr. Darby, have opined that it is reasonable that the defendant's condition has progressed to dementia?

A. Yes.

MR. LOONAM: No further questions.
THE COURT: Okay. Mr. Smith?
MR. SMITH: No. Nothing further, Your Honor.
THE COURT: May this witness be excused?
07:15:34 MR. VARNADO: Yes, Your Honor.
THE COURT: Okay. Great. Doctor, thank you so much.
THE WITNESS: Thank you, Your Honor.
THE COURT: Okay. Everyone, we will call it a
07:15:42 night. We will start again at 8:30 tomorrow. I mean, I'm sorry, yes, 8:30 tomorrow, and we will try to finish up around the same time tomorrow night.
MR. SMITH: Very good.
THE COURT: If we need to, I can -- well, if we
07:15:56 need to, we will have to come back on Friday. I mean, that's all we can do. I mean, we have got to keep going. So if you guys can wrap it up tomorrow, great. If you can't, just be prepared to come back on Friday.
MR. SMITH: The only thing I want to bring to
07:16:12 the Court's attention -- I don't know if the Court realizes -- we're not from here. We're all from Washington DC, so that is going to be very difficult for us to fly in Friday morning.
THE COURT: Okay. Well --
07:16:23 MR. LOONAM: We are prepared --

THE COURT: I'm sorry. I forgot. Tomorrow is Tuesday. The days are running together. So we have got Wednesday. Sorry. So we have got two more days. I apologize. So if we can't wrap it up by Wednesday at 7:00, we will have to --

07:16:37

MR. VARNADO: We will be wrapped up by then.

MR. LOONAM: Yeah, we're available at the Court's convenience. We're prepared to work, again, long hours tomorrow to see if we can wrap this up. We are hopeful that we can, but we are available Wednesday, too.

07:16:50

THE COURT: Okay. Great. Sorry. Lost track of days. I thought we were finishing up on Wednesday, so we have got time.

Okay. Well, let's start again at 8:30 tomorrow morning. We will keep pushing forward. Have a good night, everyone.

07:16:59

MR. LOONAM: Thank you, sir.

THE CASE MANAGER: All rise.

(Recessed at 7:16 p.m.)

COURT REPORTER'S CERTIFICATE

I, Kathleen K. Miller, certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter.

DATE: 11/26/2021 /s/ _Kathleen K Miller

Kathleen K Miller, RPR, RMR, CRR

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